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MASTERING YOUR NERVES

Practical Guidance For All Who
Suffer from "Nerves"

by

A. T. W. SIMEONS, M.D.

With 9 Illustrations

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INTRODUCTION

In which We Meet His Excellency the Brain and Talk about Witchdoctors and Others

MAGINE a fighter pilot in action. Squeezed into little gaps in bewildering maze of machinery, he sits in his cockpit. A soft, pliable, highly vulnerable creature. His tender fingertips would shrink from the prick of a pin, but with them he controls a huge mass of concentrated power. Merely with a glance he checks rows of wavering indicators on his panel. He thinks in split seconds, in the smallest fractions of an inch and instantaneously translates such thought into action.

Somewhere, far back in his mind, there lurks the realization of death and danger. Yet out of a complexity as great as that of a symphonic orchestra there emerges a magnificent harmony, a melody of action, perfect sequence, balance and synchronization. Like the conductor's baton his will rules over this indescribable intricacy and multiplicity of biological feats.

I have chosen one example, but the direction of a scene in a motion picture studio, the performance of a major surgical operation in a modern theatre, highspeed stenography, working a telephone exchange, are but a few illustrations of the perplexing tangles of time, space, will and action which the brain is able to unravel and wind into an orderly skein.

Yet the brain, for all its magnificent power of

co-ordination, is delicately poised in a quivering equilibrium. It acts and counteracts, bounds and rebounds, evades, absorbs and casts out, faces squarely or dodges the incessant onslaught of signals from the senses which stream in like the nervous and insistent clutter of a row of teletypers. With all this the brain copes with elegance, with the grace of a fencer.

Suddenly a little gust of emotion blows in from somewhere and immediately everything is changed. The beam of the mental balance begins to rock like a seismograph in the epicentre of an earthquake. The steady conscious hovering over the senses changes to erratic plunging and tossing. The harmonious, effortless ease of adaption gives place to violent and irrational reactions. As in a radio, gone suddenly out of order, the sweetest incoming melody changes to ear-rending screeches, so the normal reaction to the messages from the senses becomes distorted.

The brain being living matter, and subject to the law of the struggle for balanced existence, tries frantically to right matters. Where did that almost imperceptible gust which created such havoc come from? What happened? What was it? The victim looks around and finds nothing.

We are accustomed to think of cause and effect. This is so ingrained in our mental make-up that the search goes on. Find an answer we must.

Primitive man was lucky, he could blame a supernatural influence. He could satisfy his urge to find a reason with an evil spirit that he believed to be possessing him. A spirit that could, at some expense and with appropriate rites, be satisfactorily

driven out.

To the savage this was as concrete, as matter-of-fact and as surely curative an operation as the removal of an offending appendix is with us today. Alas, for the *possessed* we doctors have replaced our ancient colleagues the soothsayers. The difference is that we cure some of those troubles that the medicine-man could not cure, but we often fail miserably where he scored his most spectacular triumphs.

When man began to delve into the mysteries of his anatomical interior it is not surprising that he was awe-struck with the neatly packed conglomeration of weird looking organs he encountered and of whose presence no kind of physical sensation gave him an inkling. It was inevitable that the discovery, after death, of certain abnormalities in certain organs, regularly associated with always identical symptoms during life, should lead to an overwhelming predominance of the visibly diseased organ as the cause of ailments in medical thinking.

This approach to the problem of disease produced staggering results in every sphere of man's struggle for health and longevity; it has indeed trebled the expectation of life. One thing it has not done: it has failed to emulate the medicine-man's success at exorcising evil spirits which polter through the body with an embarrassing disregard for the anatomical position and physiological function of individual organs.

Modern man with impatient arrogance dismissed evil spirits before he understood how to replace them in his rational explanation of bodily disorders. Haughtily he ridicules them as non-scientific bunkum

and when he finds himself without a satisfactory means of explaining his misery—his doctors having assured him after innumerable *tests* that there is nothing wrong—he clutches at an organ or a bodily function. It is nowadays his heart, his constipation, his weak digestion or insomnia, the climate, his rheumatism or a sluggish liver. He would rather purge his bowel than his brain.

Orthodox medicine is taught to our students in terms of organs rather than of ghosts. Unfortunately for the emotionally disturbed patient we are not prepared to extirpate a suspected organ as easily as the medicine-man is prepared to exorcise an other-worldly phantom, though many tonsils, appendices and various parts of the female generative system are still shed with alacrity. Many hope for the day when they may replace a failing heart by a Carrel-Lindberg machine, a liver by tubes running in and out of a chemical laboratory and the hazards of feeding, digestion and excretion by the blissful security of an occasional intravenous injection, much as an iron lung can replace the normal breathing mechanism. If it is—as the doctor says—"the nerves," a general re-wiring with an extra blob of solder on the burnished terminals would, they think, be a good idea worth striving for in research laboratories.

Diagnostic methods have today been perfected to such an extent that a case in which a thorough and competent investigation fails to reveal an organic lesion, later found to be present, is regarded as a freak. It is worth publishing in a scientific journal. Thus when a well qualified physician assures his patient that all tests are normal, that

there is nothing wrong, the patient may generally take it that all his organs are normal in shape and size and capable of normal functioning, although not necessarily that they do actually function normally. Such a verdict implies that, if any organs behave irregularly, this must be due to an external factor and not to any intrinsic abnormality of the organ as such or, in fact, of any organ.

These external factors may be of several kinds, such as extremes of temperature or altitude, exertion, starvation, drunkenness and so forth, all of which produce abnormal functioning of normal organs. In such cases the cause of the abnormality is obvious. Consultants are not usually called upon to investigate the violent and alarming symptoms of sea-sickness nor the palpitation experienced after stepping on a cobra.

But when such symptoms occur in the unruffled tranquillity of everyday existence the mind starts a frantic search for the external factor. It buzzes into every nook and cranny looking for the cobra in the grass, the lion behind the shrubbery, the poison in the potted meat.

One after another these theories are exploded and finally all the fears, anxieties and apprehensions cluster like swarming bees and settle on some innocent organ of the body which sighs and bends under the weight of so much unwelcome attention and ceases to function normally.

Once that happens, no amount of fiddling and doctoring with that organ is going to be of any use; indeed, it will only attract more bees. Nothing short of putting all these excited insects back into a hive where they belong will set matters right.

Most physicians do not consider it their job to handle bees and those few doctors that do so professionally, the psychiatrists, are in the public eye most unhappily associated with asylums, certifying the insane and crack-pots in general.

Broadly speaking some physicians are poor psychiatrists just as some psychiatrists are poor physicians. The two disciplines, the one old, worthy and faintly pompous, the other very young, frisky and radical, are only just beginning to be on speaking terms.

For every thousand physicians there is not even one psychiatrist. When, as in the pre-Freudian days, a psychiatrist's ambition culminated in running a lunatic asylum, that proportion was ample, but after Freud had taught us to explore the unfathomed depths of man's emotional world and had proved the existence of a vast subconscious strata of the mind, psychiatry suddenly leapt into, at first rather lurid, limelight.

Psychiatry came fully into its own during World War II. The demand for specialists became most pressing. The word "shell-shock," so common in World War I and simply another expression of the urge to find a tangible cause for unexplained symptoms, became obsolete.

The psychiatrist, now, was recognised to be as important as the surgeon for the maintenance of an efficient fighting force. Those little emotional gusts, seemingly from nowhere, were taken as seriously as the whining mosquitoes in the Burmese jungles and the steel of enemy projectiles, for they caused as many, if not more casualties.

Let us look at some figures. Dr. Joseph T. Wearn

writing in the *Journal of the American Medical Association* reports that out of 15 million men examined for military service, 1,875,000 were rejected for nervous disorders, representing 30% of the men rejected for all causes. Even after this initial screening 39% of discharges from the American Forces from January 1942,

All these men were physically one hundred per cent fit, but some emotional flicker had caught them unawares and rendered them unfit for balanced co-ordination of action. Their condition can best be described as that of an orchestra in which every instrument is perfectly tuned and every musician a master of his art, but in which the conductor has an uncontrollable nervous tick with the unfortunate result that the orchestra, fully capable of rendering symphony, does in fact produce cacophony.

It has been conservatively estimated that five out of every ten patients that call on a physician are without organic disease. In consulting medical practice the percentage is even higher.

When bodily symptoms induce a patient to consult a doctor, it is the safer bet that no organic disease will be discovered. The patient has less than a fifty per cent chance that he is organically ill. This is a most unfortunate position because the physician, by virtue of his training, can deal expertly with organic disease. He can prescribe the scientifically accepted treatment. Recovery or alleviation are the rule. Everything is clear above-board and entirely satisfactory to patient and physician alike.

Now let us see what happens to the rest.

In the first place the physician is in a quandary..

Here is a typical consulting room conversation:

The patient has been carefully examined, all routine tests have been carried out, the records, x-rays, etc., are on the doctor's table, the patient has arrived to hear the verdict and get his prescription.

PATIENT: (*optimistically jocular*) Well, Doctor, what have you found? Let me know the worst.

DOCTOR: The examination shows nothing abnormal whatsoever. (*A dark shadow spreads over the patient's face.*)

PATIENT: (*threateningly*) So you mean to say I am imagining things? I am hysterical? That's what you doctors always say when you can't make a proper diagnosis.

DOCTOR: O! Not at all. I never said anything of the sort. You should be glad that there is nothing seriously wrong.

PATIENT: What do you mean, "there is nothing seriously wrong"? I tell you I am suffering, I can't work, I can't eat, I can't sleep, I am in agony all day and you have the audacity to tell me there is nothing seriously wrong.

DOCTOR: When I say nothing serious, I mean that you have no disease like cancer, tuberculosis, an ulcer or an inflamed appendix.

PATIENT: I don't care what you call it. I feel miserable and ill and I have come to you to put me right, not to be told there is nothing wrong and that I am imagining things. I am no fool. I tell you I have pains and I am not imaginative. If you suffered what I suffer, *you* wouldn't pass it off as imaginary. I am not a child.

DOCTOR: (*Hiding his exasperation under a cloak of professional gravity*) The trouble is that you are

on the verge of a nervous breakdown. You are suffering from cardiac neurosis, a spastic colitis, functional dyspepsis and a beginning myositis in the back muscles.

PATIENT: (*Much more friendly*) O! I see, so I am suffering from something after all. Why didn't you say so at once? Right, now what do we do to get all this put in order.

I have got to get well, so go ahead and prescribe some good injections or whatever you think best.

And thus begins the weary and rarely effective process of modern exorcism.

One might think that in such cases the physician could bluntly say:

"Your case is not in my line, go and consult a psychiatrist."

But this has snags. Firstly the patient would be mortally insulted.

"So you think I am mad, do you? Good day, Doctor."

Secondly, many psychiatrists are as insufficiently equipped to deal with the majority of these cases as is the physician. Their approach is frankly psychological, whereas the patient thinks entirely in terms of bodily ailments. They confer at cross-purposes. While the psychiatrist may be at pains to unravel a complex, the patient is searching for relief from his "heart trouble," his "indigestion," his "tiredness," as the case may be. He neither wants to hear nor talk *psychology* and that is what he is liable to get.

Most patients drift back to the physician. He, at least, seems to be really worried. His language is familiar. He, at least, uses a stethoscope, taps and

palpates, looks at your throat and has tests done. The psychiatrist does not appear to be interested in the patient's "real" ailments.

Psychiatry is in its own proper sphere a highly developed discipline, it is far more specialized than the physician's field. It is not the psychiatrist's job to differentiate between organic and functional disease. Patients with bodily symptoms will almost invariably consult a physician first.

If the physician finds a growth, he will condition the patient to the advisability of an operation before he refers him to a surgeon. The patient knows exactly why he consults a surgeon. But if, on the other hand, the physician finds no organic basis for the patient's complaint and abruptly refers him to a psychiatrist without previous conditioning, the patient is put into much the same position, as a surgical case would be, hustled into the hospital, clothes ripped off, strapped to the operating table, a mask clamped over his face before he knows what is happening to him.

The patient, and even more so the psychiatrist, has to pay dearly for any clumsiness on the part of the physician who first investigated the case. If physicians knew as much about psychiatry, as they do about surgery, all would be well. Often they do not, because they have never studied the psychiatry of everyday life; nor have they been taught to recognize the commonness of basically emotional disorders.

The average physician is only just beginning to realise that there is a far more rational treatment for a high percentage of his cases than is contained between the covers of the pharmacopoeias of the

world.

The general practitioner can skilfully conduct childbirth. He can perform minor operations. He can empty an overloaded bowel. But he boggles at a neurosis and is easily tempted to evade the issue with a few platitudes such as, "don't worry; it is nothing serious, just nerves." His standby for a simple neurosis is unfortunately a "tonic," regardless of the fact that the patient suffering from a neurosis already has too much tone and really needs a sedative.

The conscientious physician may say to himself: Right, let us get down to this psychiatry-business. Let us find out what to do with patients who are obviously suffering and where I am at a loss to discover the cause. He starts reading, he labours through text books, monographs and articles. It is all very fascinating, but he cannot possibly start a psychoanalysis in every case that complains of palpitation, heaviness in the heart region, etc. The more he studies the more he feels that there is something unreal about the whole thing. His reading does not furnish him with a practical directive to tackle the type of case that crowds his consulting room. He is acutely aware of something missing.

He knows his patients only too well, the businessman, the housewife, the clerk, the banker, the shop-girl, the professional man. They all come to him intensely preoccupied. Is it impending heart failure, cancer, syphilis, tuberculosis, and if not what is it?

If he starts probing them with psychoanalytical methods he might as well close down his practice. These patients, accustomed to deal with hard facts,

want something definite, something concrete, which they can grasp. They have a complaint, a very real complaint, they want to know what is wrong, they will not be satisfied with a verbosity which to them is so much gibberish, and verging on gibberish is often what the amateur psychiatrist produces, particularly when he is a physician whose whole way of thinking is in terms of diseased organs rather than personalities.

Big words like complexes, repressions, anxiety neurosis and so forth abound and leave the patient hopelessly bewildered. The expert psychiatrist uses these words in communication with his colleagues. His therapeutic manœuvres are not encrusted with such technical terms.

Many good and experienced physicians are good psychologists, because they are good observers with a deep understanding of human emotions. Instinctively they do and say the right thing, but they cannot clearly state how and why they do it. Their ability is not teachable and therefore not scientific. Modern psychiatry, on the other hand, is teachable, because it follows consciously one or the other accepted procedure.

In its present form psychiatry is the youngest branch of medicine. Its youthful turbulence is regarded with grave suspicion by the older, more settled, discipline where a much higher degree of sedimentation and clarification have taken place, where the sifting and grading of observed facts has reached a much greater perfection and where the orderly grouping of such facts into wide theoretical concepts has gone much further.

In the older disciplines the, always tempestuous,

realm of pure research has moved into a sphere far and remote from the routine of everyday practice and is increasingly becoming the domain of chemists, engineers and pure biologists who have never dealt with a patient in their lives.

With psychiatry this is not yet so. The practising psychiatrist is still embroiled in the clash of conflicting schools of thought and theory. He is still free to follow his predilections. He approaches his subject as a research worker. This naturally embarrasses the man who, with no intention to further that particular branch of science, is looking for clear guidance, for a solid foundation of fact and accepted theory upon which he can mould his management of functional disturbances.

Psychiatry, for all its remarkable progress, has not yet evolved a cut and dried foundation. Its bed is still liable to sprout into succulent verdure at any moment. That is also the reason why it is so difficult to promulgate a satisfactory curriculum for the teaching of medical students in this discipline.

As long as psychiatrists continue to wrangle about fundamental concepts, physicians will continue to flounder in the management of a large number of their cases. As long as psychiatry is preoccupied with a relentless fratricide, it is understandable that the physician tries to keep out of the crossfire, though he is impatiently awaiting the outcome so that he may garner something dependable into his therapeutic repertoire.

Meanwhile the need for clarification of the position as far as our patients are concerned is becoming more and more pressing. Some sort of technique has got to be evolved to get the patient

out of his present dilemma. Psychiatry, still in the thick of its own battles, has not yet been able to provide just what is wanted. Until it can, physicians must be pardoned if they are embarrassed when called upon to deal with a neurosis.

The general intrusion of the objective and impersonal laboratory, x-rays and self-recording instruments into medical practice has cast up neurotic disorders where they were previously not suspected. In the old days the doctor said: "It's anæmia," and anæmia it was. Pills and injections proved most satisfactory exertionists. Today the patient insists on a bloodcount, if it proves to be normal, the happy theory is exploded and so with one test after another. The patient gets more and more worried, while his doctor gets more and more hamstrung. Little wonder then that a loud Quack! Quack! round the corner attracts the patient's attention. The old medicine-man in a new garb scores again.

Apart from the many difficulties already referred to with which the management of simple, nervous disorders is beset, the busy practising physician has another factor to contend with, that is time.

The patient suffering from bodily complaints of emotional origin, must have matters explained to him and that may take anything from one to two hours, usually with dramatic results, far in excess of what might be achieved with a course of injections. But the patient who would be quite content to pay a reasonable fee for an injection, taking five minutes of the doctor's time, would be outraged if he were charged 24 times that sum for two hours' "talk," though such an interview can be as strenuous for the doctor as a major operation is for a surgeon.

It certainly requires as much conversational dexterity as an operation requires manual skill, moreover the results of clumsiness can be equally disastrous.

The problem, as it stands today, is, therefore, to find a way of bringing relief to the patient without over-burdening the physician.

The only answer seems to be to furnish the patient with an outline of the procedure the modern physician is likely to adopt in disorders of this kind. To solve for the patient that exasperating conflict into which he is thrown when feeling ill and really suffering, he is authoritatively told that his body is healthy and that no sign of disease is detectable.

Unless matters are very carefully explained to him no patient in the world will accept without reserve the dictum that his indigestion or his palpitation is merely the result of being overworked, rundown or nervous.

He wants to know WHY his heart beats fast. WHY he cannot breathe freely and WHAT makes his back ache and causes that terrible fatigue.

It will help the patient as well as his busy doctor if the former understands how mental processes can produce bodily symptoms resembling those of diseased organs. It naturally remains with the doctor to decide which it is, but once the absence of organic disease has been established beyond doubt, the real work of explaining the sequence of cause and effect begins.

The intention of this book is to prepare the patient and put him on the right track. It deals with such bodily symptoms as cause anxiety and which cannot be attributed to organically diseased organs, it is intended to smooth the difficult passage

from negative clinical findings to a positive approach to an emotional strain, manifesting itself in bodily disorder.

PART I

THE DEVIOUS WAYS BY WHICH OUR NERVES GET THE BETTER OF US

CHAPTER I

Through Our Being Misinformed about the Way They Serve Us

WHENEVER the condition of the mind—*psyche*—is responsible for disorderly function of the body—*soma*—we speak of a psychosomatic disorder.

Here we shall only be concerned with such psychosomatic disorders as are not associated with visible or measurable diseases of the inner organs as such, though nowadays the term psychosomatic is also applied to a much wider field, namely, diseases in which there are actually visible abnormalities, such as some cases of high blood pressure, duodenal ulcer, asthma, certain growths of the womb, all of which are now recognised as having their beginning in an emotional disturbance. They require medicinal as well as psychotherapeutic treatment. With this branch of psychosomatic medicine we are not here concerned. Thus when, here, we speak of a psychosomatic disorder we are referring only to a disorderly function of anatomically normal organs.

The classical psychiatric approach to a psychosomatic disorder is to unravel the emotional conflict

which is at the root of the trouble. The bodily symptoms are looked upon as an expression of this conflict. It is hoped that, once the conflict has been dug out and exposed to the light of conscious contemplation, the bodily symptoms will subside.

This analytical method scored triumphs in the hey-day of Freudian psychoanalysis because psychiatrists then dealt with frankly nervous symptoms of an obvious and imposing kind. Major cases, one might say. In such cases it is still the most successful method.

But the physician continued to hold his own in the, now ever-increasing, field of minor everyday neurotic complaints, of a purely bodily kind. In most of these cases the *conflict* is itself fixed to the physical discomfort or disability. It is often only a fear of disease that interferes with a normal functioning of the system.

In such cases analytical methods will not produce very satisfactory results because there is nothing to analyse beyond the distress which brings the patient to the doctor.

True, an emotional strain usually starts the trouble, but once the complaint has developed, the nature of that strain is of very little importance. Its elucidation is certainly not an essential condition for obtaining relief. Minor psychosomatic disorders can be cured without the use of a psychological probe. They yield best to a careful explanation of the bodily mechanisms involved which, once fully understood, cease to cause anxiety.

This method works in the opposite direction of psychoanalysis. It begins with the somatic—bodily—symptoms, and offers the patient a simple phy-

siological explanation of his disorders. The explanation must cover all the symptoms and satisfy the patient's reasoning. As long as it strikes him as illuminating and good, sound commonsense, it achieves its object. Psychiatry, in the usual sense, does not enter into the picture at all, except in general terms such as fear, anxiety, worry, apprehension, etc.

If nervous patients can be given a satisfactory explanation of what happens in their body to cause them suffering and if their symptoms are discussed in the same frank and assured manner in which a doctor explains a kidney-stone colic, the patients will follow with intense interest, their frantic search for a reason will be appeased and the anxiety, bred of uncertainty, will vanish.

Simple physiological explanations can be formulated for every psychosomatic disorder and such explanations the patient is only too eager to accept, if they are presented in a lively and confident manner, making the harmlessness of the condition become self-evident.

Here is an example of an interview with a physician which illustrates what I mean.

A terrified patient confesses to a violently itching rash which he has noticed for some days on his body. He has hesitated to consult a doctor because he has a guilty conscience and cannot face the certainty that he has syphilis. After squirming in his seat he reveals the horrid lesions. The physician takes one look and says:

“ My dear chap, you have bugs in your bed. Sprinkle it with DDT.”

The patient takes a deep sigh.

"Are you sure, Doc?"
"Positive!"

A smile spreads over the patient's face. He clutches the doctor's hand as if he had just been snatched from the jaws of death. He stalks out of the consulting room, a new man.

That is what I mean by a simple explanation.

This doctor was a good psychiatrist. Had he not been, he might, with full scientific justification, have said:

"You are suffering from multiple erythematous lesions, almost certainly of external, toxic origin, associated with severe pruritis, which will be troublesome to eradicate unless you are prepared to contemplate a change of nocturnal environment."

"Aha!" the patient would conclude, "I suppose that is a polite way of saying that I have syphilis after all. Just as I thought. Good God! What now?"

To our good physician it is a case of "bug-bites" though to the psychiatrist it is one of "syphilophobia," fear of syphilis.

Both are right.

Syphilophobia was certainly the cause of the greatest mental suffering, but the simple, positive assertion: "It's bugs," brought instantaneous relief which no amount of blood tests and the assurance that it is *NOT* syphilis could ever have achieved.

The patient suffering from a simple psychosomatic disorder wants to know what he HAS got, not what he HASN'T. Giving him negative assurances is just so much time wasted. As long as he is actually suffering he will be unable to overcome a harassing scepticism. Given something positive which he can

understand, he accepts it with almost pathetic gratefulness.

It is the mystery which surrounds a nervous complaint which keeps it going. A conjurer can stagger you only as long as you do not find out how the trick is done. Once you are in on the secret, all he can elicit is a knowing smile.

Our nerves are incredibly clever. They have to be, to run as efficiently as they do, that fantastically complicated and compact plant—our body. Compared with their methods our best mechanical, electrical and chemical achievements are primitive, childish and clumsy.

When we try to interpret nervous activity, it is like trying to explain the electronics of a large modern calculating machine in terms which the driver of an old-fashioned steam-roller would understand.

And yet something can be done about it.

Our conjurer can show us how he does a sleight-of-hand trick, perfected through years of practice, and though we cannot do the trick ourselves, it then no longer baffles us.

Our attitude from being dumbfounded changes to a sense of admiration for the conjurer's dexterity. Again as in the case of the conjurer, the uninitiated keep an unflinching watch on his sleeve, while all the time the rabbit is in his spacious tailcoat pocket. Similarly the nervous patient is always watching the wrong thing because he is not in the know. That is why he cannot solve the mystery. Once he is told where to look and what to watch, it all becomes surprisingly easy to understand. With most of the common nervous complaints that understanding is

all that is necessary.

Our nerves will put up with no end of bullying. Try as we will, we cannot make them behave as *we* think they should. They will always go their own, wiser ways. It is foolish to get exasperated about this. It is behaving like a child that goes into a tantrum because mother will not allow it to play with the carving knife. Like many busy mothers our nerves cannot sit down and calmly explain why a carving knife is not a toy and so we think they are being most unreasonable, while they are in fact doing the right thing.

It is here that some explanation is called for. We grown-ups are open to reasonable persuasion but we strongly resent being bossed about by little bits of living tissue in our own body. We have been brought up to believe in *mind over body*. So we get terribly alarmed when the body shows signs of usurping power over the mind.

When mind and body quarrel it is always the body that comes out on the top. The human mind is often foolish. The body never. In these quarrels the body is usually right.

The trouble with the mind is that it does not appreciate this fact and so it continues to hurl unjustified abuse and slanderous invectives at its humble servant. It is all a matter of ignorance about how body and its nerves work. A disastrous mental dabbling in anatomy and physiology based on a very imperfect knowledge of both.

Once we understand their ways, our nerves cannot get the better of us so easily. That is the importance of instruction in dealing with psychosomatic disorders.

In the next few chapters we will discuss the workings of the nervous system in relation to the organs of the body in general. Later on, in Part II, we will deal with some specific complaints. It is very important that the general principles are fully mastered before turning to the second half of this book because there we shall be continually referring to these principles and any haziness about them will render the interpretation of nervous symptoms much less clear.

CHAPTER II

Through Letting Us See what Goes on Behind the Curtain

THE inside of our body is humming with mechanical, chemical and electrical activity. The heart is pumping unceasingly and the bellows of the lungs are moving at the pace and volume required at any moment. The glands are busily manufacturing their respective secretions. A heavy traffic is running through the digestive tunnel.

To reproduce all this activity by man-made means, a huge plant covering several acres would be required, with hundreds of workmen and technicians. The noise of the workshops, the traffic-lines and power-stations would be deafening, but of all this internal activity we feel and know nothing.

This is because we all have a certain threshold of consciousness for inner bodily sensations below which we feel nothing of what happens in our body.

It is like a screen which separates the kitchen, where the food is actually prepared, from the dining room, where it is served. Our conscious mind has no business to go prying behind this screen. That is where the Chef rules supreme and not the Master of Ceremonies—the brain.

In organic disease or fever the internal activity of our body increases in an effort to put things right. There is an emergency and suddenly the activity rises above the threshold. The whistling of steam and the smell of burnt milk issues forth from behind

the screen. We register pain or discomfort. We consult a doctor, the doctor finds the cause of the trouble and gives proper treatment. In due course the emergency subsides, the internal activity returns to normal and sinks below the threshold of consciousness. Well-being is fully re-established.

This can be shown in a graph (Fig. I).

The graph represents a day from midnight to midnight. The lower continuous line shows the normal internal activity which is low at night during sleep. Awakening, feeding, working, etc., bring about an increase of this activity. The graph rises. In the evening it settles down again and soon reaches its lowest point during sleep.

Well above this line you see the normal threshold of consciousness, indicating that of all the varying degrees of normal internal activity we feel nothing because they remain below the threshold of consciousness. Now let us assume that real disease—say fever—abnormally increases this activity as shown by the dotted line. The activity has suddenly risen above the threshold and so we register a feeling of illness and do something about it.

A common and very important occurrence in psychosomatic disorders is an abnormal lowering of this threshold. If we stick to our metaphor it is just the same as taking the screen away from the kitchen-door where it belongs and placing it in the middle of the kitchen, with the result that suddenly the clutter of pots and pans becomes audible to the diners.

This is shown in Figure II.

Here we have a similar graph as in Figure I. Again there is the continuous line, indicating the

FIG. 1

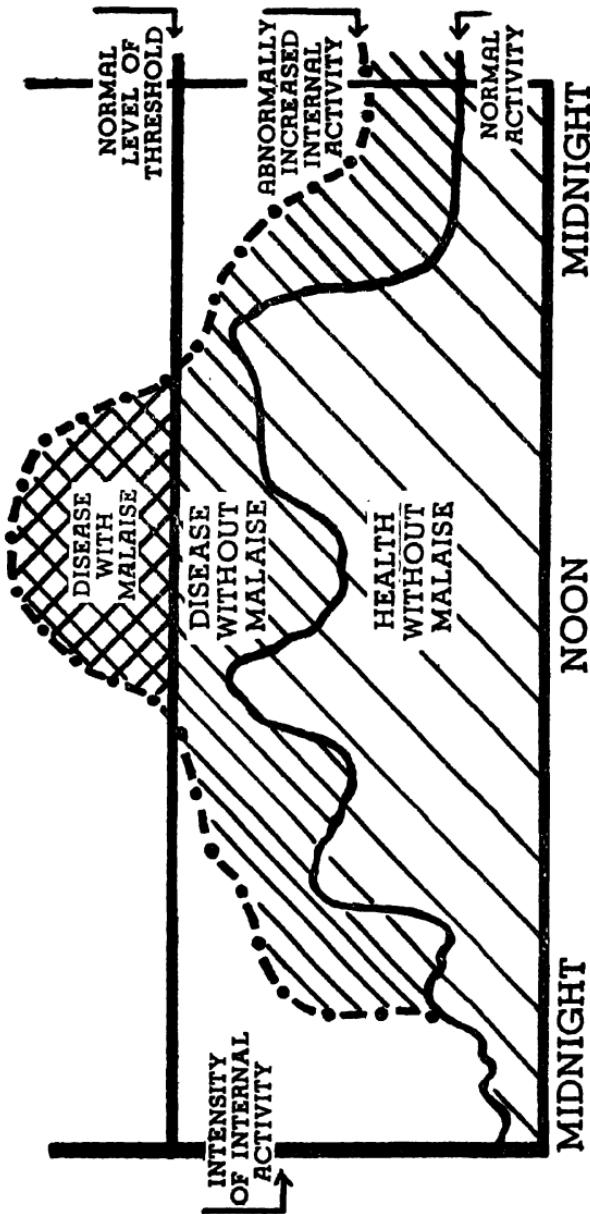
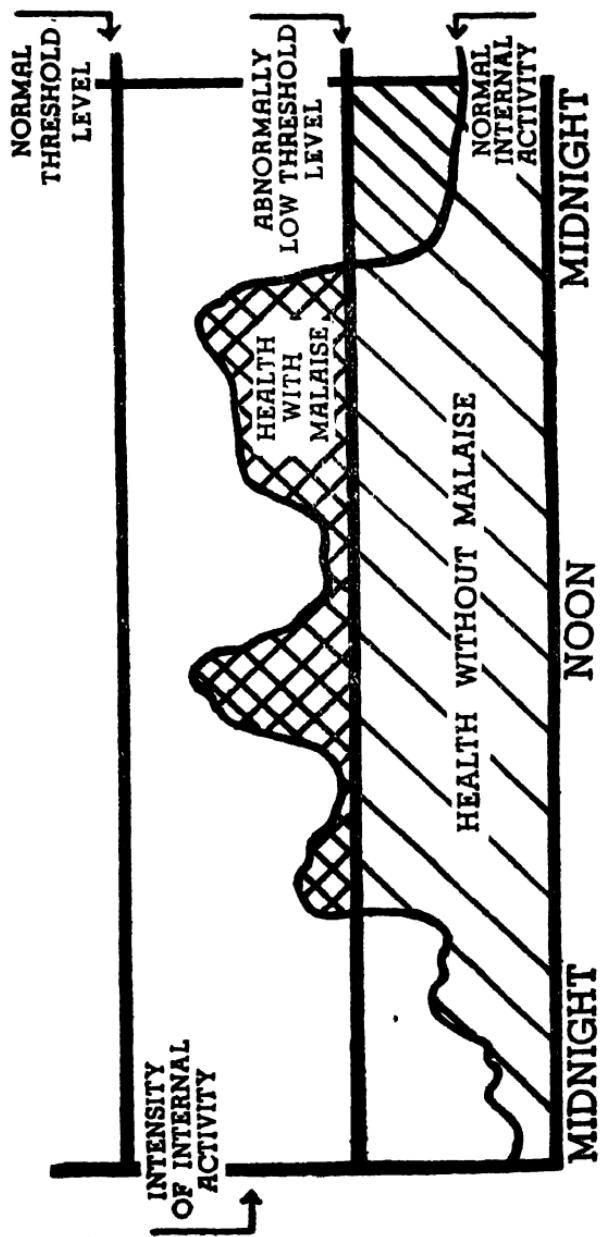


FIG. II.



normal range of internal bodily activity. Well above it is the normal threshold. But now a second straight line shows the position of an abnormally low threshold. This line cuts straight through the peaks of the graph. This means that all the areas thus cut off—they are cross-shaded in the figure—are consciously registered as pain, discomfort, malaise, in spite of the fact they are still within the perfectly normal range of internal activity. It is the degree of awareness which has changed, not the activity as such.

The unpleasant awareness of internal functioning is the same whether this is caused by an abnormally increased activity or by an abnormally low threshold. The sufferer is unable to distinguish between the two. Hence his deep-rooted scepticism, when told that he is organically healthy. His plausible argument is:

“But I did not feel like this before I got ill.”

That argument has got to be satisfactorily answered.

It is, therefore, necessary to explain further how and why a normal threshold can sink to a subnormal level.

The level of the threshold depends on the attention paid to the body and the degree of apprehensive preoccupation. I will illustrate this.

The man who wants to shoot a panther at night sits perched in a tree overlooking the kill. He has a long vigil before him and he must remain silent and motionless. He wants to clear his throat, his seat is most uncomfortable; he would almost sacrifice the panther to stretch his numb limbs, the mosquitoes torture him. His threshold for bodily

discomfort is very low and so he suffers miserably.

Suddenly he becomes aware of the panther's approach. His threshold for bodily discomfort leaps up because he has something far more serious and thrilling to occupy his mind and to monopolise his attention. Instantly all discomfort vanishes just as completely as if suddenly he had been softly and safely bedded in his bungalow under a mosquito-net. A change in the position of his threshold has completely relieved him of all his previous troubles.

A mother has an extremely low threshold of consciousness for her infant. She can sleep peacefully through the roar of city traffic, but a sigh from her little one will awaken her instantaneously.

A person who does not suspect that he is suffering from fever will work with a temperature of 100 degrees and be reasonably comfortable; one who is alarmed at fever will be prostrate. The former has a high, the latter a low threshold for fever. It is all a matter of anxious attention.

In many psychosomatic disorders apprehensive attention is fixed on a particular organ or function. This at once lowers the threshold for that particular organ and its function. The result is that the slightest variation in activity is registered consciously and interpreted as a sign of disease, though actually the variations are well within the normal range. A wind becomes a colic; a stomach full of air becomes a heart-attack; a tired limb, impending paralysis; an increased tone in the back-muscles, kidney disease or T.B. of the spine; indigestion, the first sign of cancer.

"My symptoms are just the same as my father (brother or friend) had shortly before he died of

cancer," is a common phrase. Very naturally such notions produce fear and anxiety which lower the threshold still further.

All the internal activity in the body is governed by a nervous system which is largely independent of the higher centres of the brain. We call this the **AUTONOMOUS NERVOUS SYSTEM**.

The autonomous—or independent—nervous system runs our digestion. It controls the circulation and the pressure of the blood, the maintenance of body-temperature, the breathing, glandular activity, sleep, the mechanisms of excretion and sex. It controls the tone in our muscles and the sweat glands in the skin. It makes us blush or turn pale. It also makes our hair stand on end, as when we get goose-flesh (*presumably goose-skin* is meant).

Though the autonomous nervous system does not directly control our thoughts, our thoughts keep it extremely busy, making such internal adjustments as will best fit the body to carry out what the brain is thinking of or intends to do next.

This autonomous nervous system is amazingly efficient. We need only register the smell of good food, and instantly the mouth begins to water and the stomach is made ready to receive a hearty meal. We need but think of danger to make the heart beat faster and increase the blood supply to the muscles so that, if need should arise, we will be better able to run.

For the same reason a fright stops our appetite. The wise autonomous nervous system reasons: if run we must, let us do so on an empty stomach. It cannot rely on the brain's sense in such matters. So it puts an end to any nonsense by conjuring up

a spot of indigestion. The brain—often not realising how frightened it is—cannot understand the reason for this sudden indigestion. It blames the shrimp-paste, becomes indignant and still more frightened to which the autonomous nervous system responds with more indigestion and rightly so because, from its own point of view, the emergency has increased. Therein lies the making of a rather stupid quarrel.

The autonomous nervous system consists of two equal halves like the scales of a balance. It maintains the body's normal functioning by establishing equilibrium between these two halves. For instance, stimulating the one half—which we can call the heart accelerator—makes the heart beat faster. Stimulating the opposite half—the heart-brake—makes the heart beat slower. When they are equally stimulated as in health, the heart beats normally.

Of course, we can also do the opposite. We can suppress the heart accelerator and thereby slow down the pulse or we can weaken the heart-brake and thereby increase the speed of the beat. If we depress both equally the rate will remain unchanged.

We possess drugs with which we can stimulate or depress either of the two halves of the autonomous nervous system. Of this fact the doctor treating a psychosomatic patient often makes good use. This is how it works.

It is easy to understand that when the autonomous nervous system is kept in a state of constant alarm, because the brain is incessantly hoisting danger signals, it becomes over-exerted. The balance becomes overloaded. This prevents the establishment of a steady equilibrium because the balance has become too sensitive. The same thing would happen

if someone tried to weigh a potato on a chemist's fine analytical balance adjusted to register one thousandth of a grain; he would find it impossible to do. The balance would never come to rest.

In the same way the over-burdened autonomous nervous system becomes erratic and cannot be brought to rest. If the brain would stop its antics, equilibrium would be easily achieved, but often nothing short of chloroform will stop this stubborn organ of ours from fretting and fussing, once it gets into a real dog-fight.

Fortunately, modern science gives us the means to deal directly with the good old sensible autonomous system without bothering about the brain's jittery behaviour. The doctor and the autonomous system can join in a little conspiracy to fool the brain back into the normal behaviour.

The doctor agrees to give the over-worked autonomous system a well-earned rest by slightly doping both halves. This makes them indifferent to the brain's rude bawling. They stop taking the brain seriously and as a result the internal activity is reduced to a level well below normal.

This has a very steadyng effect on the balance, though the physiologically boorish brain does not appreciate this. What it does appreciate is that all of a sudden the internal activity has dropped below the lower threshold. Where before it noticed a noisy commotion, peace and quiet has been restored. The delighted brain thinks that now all is well, whereas actually abnormal conditions have been artificially established.

This foolish but happy notion that a disease has been cured, results in an immediate rise in the level

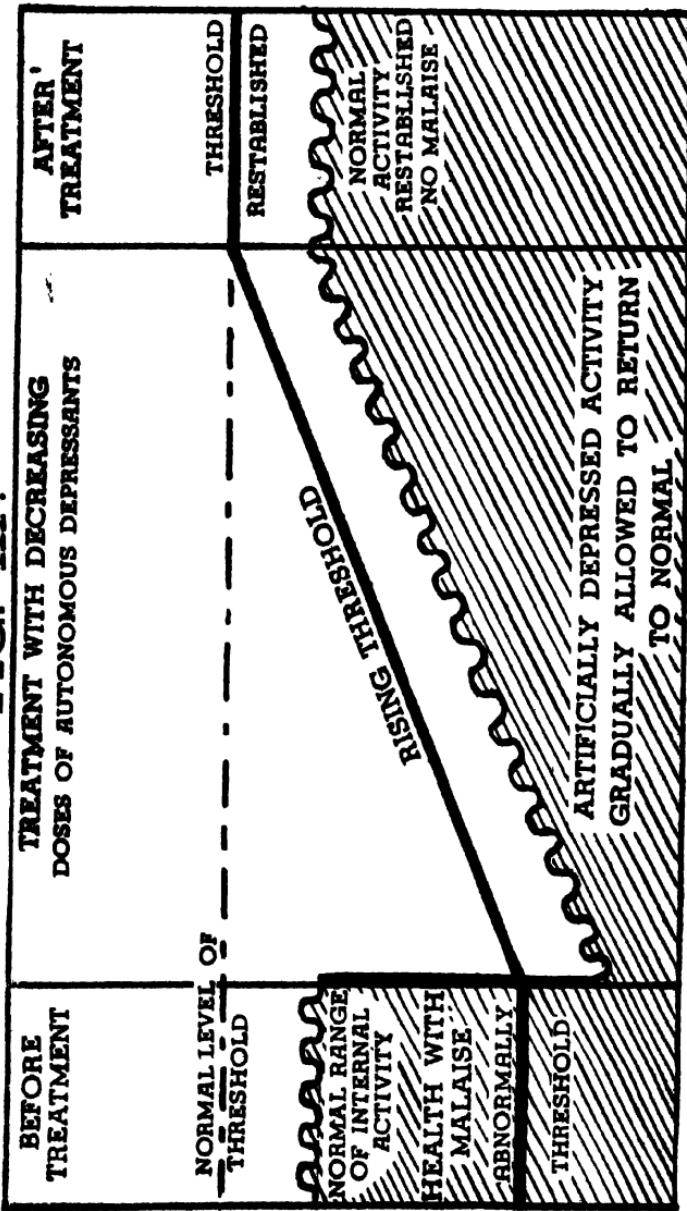
of the threshold. So, after a few days, the doctor can reduce the dose of the autonomous dope. The internal activity rises a little, but still stays below the now higher threshold. As no more unpleasant symptoms recur, the threshold rises in the course of 2 to 3 weeks back to its normal level, slowly followed by the autonomous system which is gradually allowed to regain its normal level by decreasing the dosage of the drug. When finally medication is stopped things are exactly as they were before it was started, except that now the patient's threshold is back where it belongs and he, therefore, no longer feels what is going on in his inside, though in actual fact the activity is neither less nor different from what it was when he was suffering bodily and mental torture.

This is illustrated in Figure III.

It is really just a clever trick which is, however, remarkably effective. It brings the screen right up against the door of the kitchen. Just because the scullery boys have been temporarily hushed the Master of Ceremonies is satisfied that all is well in the kitchen. He loses all interest in what goes on in there. He does not realise that behind the curtain the scullery boys are at it again with renewed zest after their compulsory shut-down.

The lowering of the threshold of consciousness for the inner working of our body is a factor of greatest importance in understanding how the mind can register disease in a perfectly healthy body. It is a basic principle that must be thoroughly understood before we can hope to overcome the alarming results that are inevitable as soon as the threshold starts slipping down and growing anxiety speeds its further descent.

FIG. III.



I hope the reader will not take it amiss if I ask him to go over the three diagrams once more to make quite sure that this rather complicated matter is perfectly clear to him as in later chapters we shall be constantly working with this concept.

CHAPTER III

Through Making Us Think We're Cleverer than We Are

MANY psychosomatic disorders can be traced to a continual and detailed supervision by the reasoning mind over such animal functions of the body as digestion, the blood circulation, the elimination of waste matter, sleep, and the mechanisms of sex. All these bodily activities, which are not directly and completely under our voluntary control, work best when left to themselves.

In man the higher centres of the brain have acquired an enormous weight of authority over the autonomous nervous system. In its involuntary mechanisms our body differs very little from that of the other mammals closely related to us. These functions of our body have not partaken of the phenomenal development of the human brain. They have remained at a far lower evolutionary plane.

This has enhanced the power and the authority of our brain over its subordinate centres. The lower nervous centres never question this authority, in fact, they dread it.

That the human brain was free to strike out into an almost freakish development, shows that it must have been served by extraordinarily efficient lower centres which were capable of maintaining perfect function in their respective spheres with a high degree of specialization and automatic adaption to the many problems set them by man's mentally

directed enterprises. The efficiency and versatility of the automatic regulatory mechanisms of the body has relieved our brain of many duties which its counterpart in lower animals has to perform.

In the nervous hierarchy of the body the higher centres issue only general directives. The execution of these physiological directives is seen to by subordinate, though specially skilled, centres. The higher centres have no such technical skill. Let me illustrate this with a few similes.

A man who knows nothing about driving a car can employ a trained driver. He has full and undisputed authority to tell his driver where to go, but he would be courting disaster if he used his authority to order the driver to press this pedal or move that lever. No one would blame the driver for disobeying such orders from a man, even if he is his boss, who cannot drive a car himself, and if the boss persists, the driver would step out of the car and with the words, "If you know so much better, drive your own car," quit the job.

Here is another example to clarify this situation.

A charwoman has worked for many years in a large bank. She is punctual, regular, industrious and all are satisfied with her work. By nature she is quiet, polite and shy. She knows her place.

One morning the President of the bank comes in, before opening time. The charwoman is cleaning his office.

PRESIDENT: Now, my good woman, hurry up, I have got a conference here in fifteen minutes.

CHARWOMAN: Yes, Sir.

(*She starts scrubbing frantically. The President, smoking a big cigar, looks down at her.*)

PRESIDENT: But, my dear woman, how do you expect to get the floor clean with that dirty water in your pail. And isn't it about time you got yourself a new scrubbing brush. Look at this filthy old rag. Careful, now, don't splash over my carpet.

CHARWOMAN: No, Sir.

PRESIDENT: But you have already done it.

CHARWOMAN: Sorry, Sir.

PRESIDENT: Sorry, sorry, fiddlesticks. Get on with your work, but don't let me see you use such dirty water again. Surely there is enough clean water in the tap.

CHARWOMAN: (*Getting more and more flustered*) No, Sir, I begs your pardon, Yes, Sir.

PRESIDENT: All right, Mrs. What's-your-name — Just wipe up and clear out.

CHARWOMAN: But what abaht the hash-trays, Sir?

PRESIDENT: Ash-trays be damned! Will you go now.

CHARWOMAN: Yes, Sir! (*suppressed sobs. In her confusion she knocks a costly vase off the desk with her broomstick and trips over the pail.*)

PRESIDENT: (*Has a stroke.*)

If the President had said:

"Good morning, my good woman, quite chilly, isn't it?" and had then proceeded to study the minutes of the conference which is what a wise and balanced President would have done, no disaster would have occurred. As it was, he paid the penalty of abusing the charwoman's better knowledge and skill by the weight of ignorant authority. How could a humble charwoman explain to the great President that an old rag and an old scrubbing brush

are far better than new ones. She wouldn't have the cheek. And in any case she had to keep the job.

The mechanisms controlling the animal functions of the body are like highly skilled workmen in an industrial plant. The higher centres of the brain are like a board of managing directors whose place is in the office and the boardroom. If the general managers spend their times in the workshops, technically admonishing the turners, the drillers, the smiths, carpenters and fitters, instead of leaving that to their shop-foreman, the company will never prosper. The skilled workers, each a specialist in his field, will become disgruntled, the best ones will leave. The quality of the workmanship will deteriorate, the output will be lowered, the work the managers are paid to do will be neglected.

This situation lies at the root of numerous psychosomatic disorders.

A typical example is habitual constipation. The victim starts off with the purely intellectual assumption that going more than 24 hours without an evacuation is very bad for him. There is not the slightest physiological support for this assumption. It is in fact, wrong. Yet the patient treats himself to an altogether excessive purge, practically emptying his gut. He restricts his intake of food and then, pathetically naive, expects a normal, voluminous stool the next day. This being physiologically impossible, he gets really angry with his, as he thinks, sluggish bowels. His bowels are, of course, absolutely normal and would, if left alone, discharge their waste matter as and when required for their purpose.

But no. Instead of leaving the job to them, he

takes matters into his own ignorant hands. I will teach them to behave, he thunders, and so he begins with laxatives, stronger laxatives, purges and stronger purges, in a crazy crescendo culminating in a daily enema. He has successfully ruined a perfect piece of bodily machinery through sheer, clumsy stupidity backed by the authority of the mind against which his faithful servant, the bowel, has no redress.

He has flogged the willing dray horse almost to death because it doesn't run as fast as last year's Derby winner which he jolly well thinks it should.

The patient has to pay dearly for his blundering and his lack of faith in mechanisms grown and perfected in millions of years of biological evolution. Mechanisms which are, in fact, far older and wiser than the cerebral protuberance of which man is so inordinately proud.

We shall have frequent occasion to refer to uncalled for supervision by the mind in later chapters, because in so many psychosomatic disorders turning the intellect out of the animal body and making it revert to its normal duties is the most important preliminary to recovery. This can be achieved by a careful explanation of what is happening.

The skilled workmen in our body must be relieved of the General Manager's most unwelcome presence at their bench. As soon as they know him safely back in his office they resume their normal efficiency. What the psychosomatic patient does not realise is how extremely efficient his various organs really are. That they are not slack and sluggish but only embarrassed by too much conscious limelight with which the brain, suspecting some mischief, floods their little workshops. It is actually something like

stage-fright which is upsetting them.

Let us take an example: a patient complains of sudden and alarming attacks of palpitation which occur when he is upset or annoyed, or even in his sleep. He consults his family doctor. During the examination the patient is naturally nervous and is dreading to hear the verdict that he has a heart disease. So, of course, the doctor finds a fast pulse; but as there are no other signs of abnormality he may suspect a purely nervous disorder, though he cannot be quite sure.

Very rightly he suggests a consultation with a heart-specialist. There the patient is again examined after a detailed history has been taken. He has an x-ray and an electrocardiogram, (an electrical tracing of the heartbeats). With this evidence before him the specialist can say definitely that the patient's heart is organically perfectly sound, even if it was racing during the examination.

Now about this verdict there can be no doubt whatsoever. The electrocardiograph does not make mistakes and with modern methods it is quite easy to distinguish between a heart which is abnormal and one which is not.

Yet the patient feels that there is something very wrong indeed with his heart and so it becomes impossible for him to reconcile the specialist's verdict with what he himself observes. Nor does it dispel his belief that no one can discover the root of his trouble when he is told that he is suffering ONLY from a nervous heart which cannot be cured with *heart medicine*.

How can we explain this paradox?

The first thing that the patient must understand

is that his heart is like a healthy child that screams because it is frightened, not like a sick child that screams because it is in pain.

Let us see what is frightening his heart.

It is normal for our brain, in a very general sort of way, to supervise our body. Every part of our body comes in for a certain amount of attention. This normal surveillance occupies a rather small sector of a general consciousness most of which is directed outward through the senses for surveying the environment or is occupied in the brain itself with the composition of perceptions and associations, that is, abstract thought.

As shown in Fig. IVA, we can picture the brain as a centre radiating consciousness in every direction, just as the sun radiates light and warmth. Fear, anxiety, apprehension, act on this benign, healthy consciousness just as a powerful lens does on sunlight. It concentrates an abnormal quantity into a focal point and can thereby produce an alarming and surprising effect. The suffering caused by a *nervous heart*, *nervous dyspepsia*, *nervous insomnia*, etc., is the result of anxiety acting as a psychological lens which concentrates an altogether abnormal amount of attention on one spot. This spot cannot but react violently to such a mental hammering.

On the other hand, it does not burn up. It is strained but not irreparably so. The moment the *fear lens* is removed the focal point returns to a happy and unperturbed tranquillity. As soon as the organ is relieved of the terrifying glare of the mental search-light it very soon settles back to its normal activity with a sigh of relief.

Not until the patient understands that the doctor

is merely trying to get out that lens which is making a nuisance of itself can he usefully co-operate. He must have a clear picture in his mind. Something tangible which he can tackle. A safe psychosomatic bridge across which he can travel backwards and forwards over the black and bottomless chasm which hitherto separated his psyche from his soma must be built. The lens concept is something he can grasp and contemplate with satisfaction and equanimity.

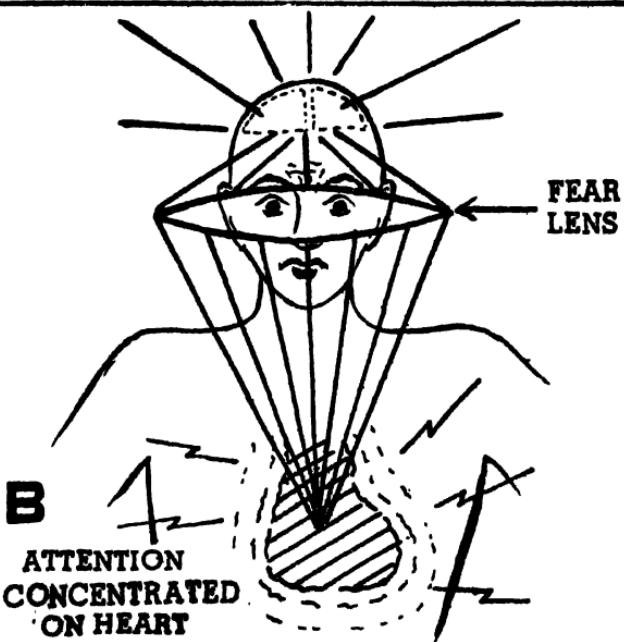
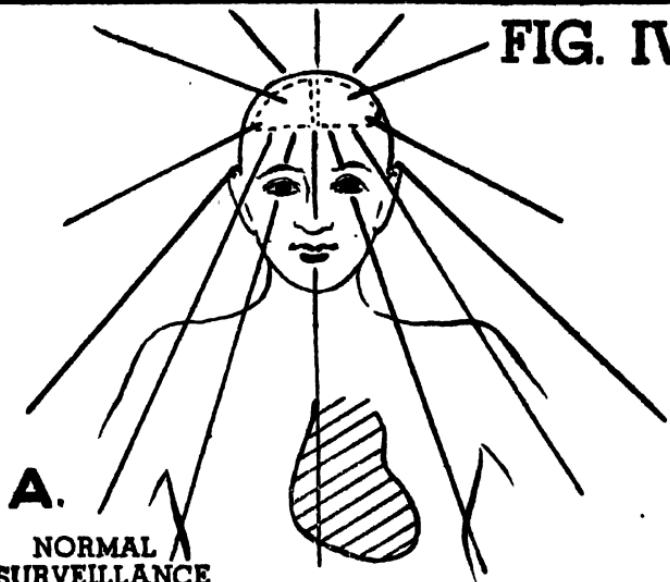
The idea is illustrated in Fig. IVB.

The two figures make it clear 'how the mere removal of the lens will instantly re-establish normal conditions. This knowledge does not in itself remove the anxiety, but it transfers the emphasis from the organ to the anxiety as such, and that is a very important initial step. It induces in the patient a reversal of cause and effect. Hitherto he was convinced that he was worried because his heart was abnormal, he now realises the possibility that his heart is abnormal because he worries. He can now understand how this is possible whereas formerly when this was simply stated as a matter of fact he pooh-poohed the idea as an insult to his intelligence.

Explaining matters like this leads the patient calmly along a road on which he picks up obvious deductions himself. He feels encouraged to take an active part in the proceedings which he appreciates much more than being subjected to a fusilade of unanswerable and incomprehensible dictums.

The psychosomatic patient is highly indignant when faced with a professionally bullying physician, however well-intentioned such robust patronizing may be. Unless the patient feels that he is taken

FIG. IV.



as seriously as he would be if he were on the point of rupturing an inflamed appendix, which indeed he deserves to be, he will shut up his delicate and tender trouble-spot like an oyster clamped in its impermeable shell. His receptivity registers zero for assurances that all is well.

It is the clever fellow who gets into this sort of trouble. In fact, he is just a shade too clever for the comfortable and smooth functioning of his animal body. This animal body behaves as if it resents the prodigal and one-sided development of our brain. It functions remarkably well in the imbecile and the moron where the brain is incapable of interference.

When a wise and trusting patient consults a competent doctor for a psychosomatic disorder and is told that there is nothing wrong he will leap from the couch and happily exclaim: "Thank God!" Just like the patient that had the bug-bites. Rightly assuming that his doctor knows what he is talking about, he will forthwith dismiss the whole matter from his mind. Such a one is cured.

Unfortunately—that is, unfortunately for so many psychosomatic patients—the alleged incompetence of doctors, luridly embellished, is a popular social topic. At such discussions the doctor incognito hears much that makes him chuckle because he realises at once that it is usually mapner rather than matter which is being thrashed out. However that may be the just-a-bit-too-clever patient is all too ready to assume that the doctors who cannot relieve him of his suffering are fools. He is sceptical of doctors without realizing that this attitude must sabotage the efforts of even the very best doctors,

much to the patient's detriment. If patients had as much simple and implicit faith in their doctor as they have in their watchmakers or the radio repairman there would be less psychosomatic suffering.

Patients indulging in an excess of mental supervision over a part of their body get into a vicious circle. As their symptoms increase they get more and more exasperated. The more exasperated they get, the worse their complaints become. Yet they can break this vicious circle by allowing themselves to be convinced that a healthy organ misbehaves as long as the brain keeps on—often subconsciously—nagging at it.

Sometimes it is not nagging, it is pampering that causes the trouble. Our organs are incredibly robust and not at all likely to give out under the strain of everyday life which hardly ever taxes them to capacity. Just as in the case of a child, nothing disgruntles them more than being hedged in with absurd restrictions or being punished—with medicines—because they are irritated at never being left alone, and allowed to behave normally. Just as foolishly over anxious parents bludgeon their children into hypochondriac misery, while they flatter themselves that they are being super-parents, so a foolishly meddlesome brain can ruin a fine and healthy organ by being just a shade too clever.

Psychosomatic suffering is the price we have to pay for the prodigious development of our reasoning faculty and we have by no means reached an end point in this evolution. Though many scientists have hazarded their views on the subject, none can say which way the further development will go during the next few million years.

The rapid increase in psychosomatic suffering which we are witnessing today may mean that our brain will gradually ruin our body. That is what the pessimist would say. On the other hand, our body and its automatic regulations may catch up with our brain, which at the moment is a troublesome, mischievous, devilishly clever *enfant terrible* as far as the body is concerned. Both these possibilities are long range views which will not make much difference for the next several hundred generations. What would make an immediate difference would be success in curbing the brain's youthful extravagance by educating it a little more into physiological maturity and reasonableness in its attitude towards that magnificent structure—the body—which guards it, moves it, feeds it, and provides it with some of its most enjoyable entertainment.

CHAPTER IV

Through Making Us Forget Good Habits and Learn Naughty Ones

WHEN we admire an acquired skill or extoll the virtues of practice and training, we are really referring to man's ability to economise on conscious effort. Practice enables an ever lengthening series of nerve-muscle events to take place without a conscious effort of will being necessary for each phase. These series run off automatically. The longer a series and the more completely automatic it is, the greater the skill, the less mental attention to detail required to perform the feat; the more rapid its accomplishment.

The difference between the beginner pecking laboriously at the keys of a piano or a typewriter and the virtuoso is one of elimination of conscious effort. Conscious effort is required in a high degree by the beginner. He is so intensely occupied with making the muscles of his fingers do the right thing that he is unconscious of the lilt of the melody or the meaning of what he is typing.

The muscles of the expert cyclist or automobile driver respond without conscious effort. Not so those of the beginner. That too is the reason for the agony experienced by the rear-seat driver who cannot stop his automatic reactions reeling off in response to the traffic. He wears out the carpet with an imaginary foot brake and clutches the hand-rail with fingers twitching to manipulate the steering

wheel. Such examples could be multiplied *ad infinitum*. They all show that the less conscious effort required for its performance, the better an action is accomplished.

Naturally, the reverse applies with equal force. During the early school years handwriting develops into an automatism. Only then does it become fluent. But when an adult tries to show a child how to write by consciously reproducing copy-book calligraphy, his efforts are often below the standard of his pupil. The reason is that he is trying to de-automatise an automatism.

The expert flier, acrobat or athlete puts up an atrocious performance when he tries to explain with a running commentary how he does it. The beginner at golf or billiards has to be told a host of things which never reach the professional's consciousness when he is playing a match. Many champions cannot de-automatise, that is why they are often hopeless as teachers and trainers. That too is why learning the grammar of our mother-tongue strikes most of us as a rather insipid and unnatural occupation. We are distracted by the observance of rules and exceptions. They interfere with the spontaneous flow of speech as we learned and practised it in the nursery.

If we did not possess the ability to automatise, life would be impossible. We would be as helpless as a new-born infant. We would be unable to speak, to walk or use our hands because we would have to direct consciously the contracting and relaxing of each of the numerous muscles involved in carrying out these activities. The development of automatism is, therefore, a psychosomatic phenomenon

of fundamental importance in the relation of nervous impulse to muscular response.

Nor is it surprising that we frequently encounter disturbances associated with this phenomenon. Such disturbances fall into two groups. The one group in which an undesirable automatism develops: we learn a new, naughty trick which becomes a habit. And the other in which a normal automatism has become de-automatized: we forget how to perform a good, old trick. In the first case in which we have developed a useless, stupid or unhealthy bodily habit which has grown so completely automatic that it has become dissociated from our will, we can get out of it by linking it up with our will once more. If we watch consciously what we are doing and observe each phase, covered by intelligent interpretation, we will so seriously hamper the automatic reeling off that it will soon become de-automatised.

Suppose you are living in a foreign country. You do not bother to learn the language seriously, yet after a while you pick up snatches of conversation and soon boldly hold forth in a reasonably good idiom coupled with an atrocious grammar. The latter you do not notice, so you grow very proud of your fluent linguistic proficiency. It has become automatised.

Then one day you decide to have a look at a grammar book. To your horror you discover that you have been talking balderdash. From then on you watch your words. Result: fluent conversation becomes well nigh impossible. You have started to de-automatize.

In many psychosomatic disorders in which the body reels off an undesirable automatic trick the

detailed explanation of what actually takes place from the first to the last phase of the performance is sufficient to make it appear ridiculous which most effectively puts an end to it. Again the value of better understanding becomes evident.

In cases in which a normal and regular automatism—say for instance, the evacuation of the bowel—ceases to function, it is usually because the over anxious patient has succeeded, through apprehensive attention to every phase of the mechanism, in de-automatising this function.

If we can allay his anxiety, this critical observation will stop and a normal automatism will be soon and happily re-established. Thus, in this case we merely reverse the procedure adopted for the other group.

The major hysterical attack with fainting, convulsions, contortions, screaming, etc., is rapidly becoming a thing of the past. This is not because people are getting less *hysterical*, it is simply because it is too well-known and too much talked about as a form of releasing pent-up emotional energy to permit that spontaneous and reckless abandon, necessary for the fulfilment of its object. The patient knowing the classical symptoms of *hysteria* would practise a certain amount of mental discernment which prevents the establishment of the hysterical automatism.

Just as we must remove this critical checking to get a normal automatism re-established, so we can use an induced surveillance to get rid of an undesirable automatism.

A great help is the fact that most bodily automatisms are to some extent *conditioned*. This simply means that an act or an impression through the senses which plays no part in the automatism

itself acts like a trigger.

A typical example of this—though not the classical one of Pavlov and his famous dogs—is the way a lot of people believe that they can precipitate the morning evacuation of the bowel by drinking a glass of water which must be either hot or, with others, cold, or by smoking or gymnastics or simply settling down to read the newspaper. None of these things takes part in the automatism of evacuation—they are merely a *conditioning* which sets the reflex mechanism in motion. With many people switching off the light and adopting a certain posture *conditions* the induction of sleep.

This *conditioning* must be taken into account when dealing with disturbances of automatism. Again it works both ways. A normal automatism can be more easily re-established if we hitch it to a voluntary *condition*. On the other hand, the removal of a condition helps in eliminating an undesirable automatism. For instance, the fairly common symptom of nervous vomiting is easier to control if this useless automatism is deprived of the usual *condition*—a basin held in readiness to receive the emotional libation.

Almost anything can condition an automatism. It may be a house, a room, a person, an item of food. Sometimes it is difficult to discover what it is, but as often as not the patient supplies the information, usually saying: "It is funny, but every time I do (hear, see, eat, touch) something *something*, I get it."

We must first decide whether we are dealing with a wayward automatism such as nervous vomiting, swallowing air, nervous diarrhoea, etc., or with a

normal automatism which has become de-automatized, such as habitual constipation, insomnia, nervous disturbances of sex, etc. In the first case our efforts must be directed to the removal of as many conditioning factors as possible and to the encouragement of a well-informed mental scrutiny of the symptoms. In the second case we should do exactly the reverse. We must try to establish *conditions* for our reflexes and remove the mental control over every phase of the function. Later chapters will show how this is done.

Here is a fable by way of illustration:

Once upon a time there was an old man with a fine long beard of which he was very proud. One day a friend asked him whether he kept the beard over or under the bedclothes when he slept at night. The question startled the old man. He thought for a while but finally had to admit that he could not truthfully answer that question. He had never thought about it. Whatever he did with his beard at night had grown into an automatism during the gradual elongation of his hirsute splendour. He promised to watch and tell his friend the next morning.

But the following day he had still not got the answer. He had spent a sleepless night. First he spread the beard out over the blanket and when that did not feel right he stuffed it under the blanket. But that did not feel right either. So he tried twisting it round his neck first to the right then to the left, but that was hot and uncomfortable. Then he tried parting it and hooking the two halves behind his ears, but that tickled intolerably. So he cursed the beard and decided to try and sleep any-

how. But he could not get out of his mind the location of his beard and so he raved and worried without a wink of sleep. The next night he dreaded going to bed. He was again tortured with barbarous insomnia. He had not only lost the ability to handle his own beard, he had in addition, de-automatized the mechanism of sleep. Eventually he had to commit the atrocity of self-mutilation. He accomplished the deforestation of his chin with a razor and slept happily ever after.

CHAPTER V

By Planting a Tiger in a Bush

FEAR, or as we politely call it, anxiety, and apprehension enter into the picture of almost every psychosomatic disorder. It is like the Sword of Damocles, dangling on a fine thread over the patient's head. At any moment, he thinks, the thread may snap, striking him down with tuberculosis, cancer or impotence. That sword has got to be removed or otherwise rendered less terrifying. Sometimes this can best be done by showing that it is not a real sword, that it is a dummy made of cardboard, or that the imaginary thread is really a stout hawser, not at all likely to snap.

Few patients realise how closely their symptoms resemble those produced by stark terror. It is well to make this clear. Here in India, where I am writing this, the following parable seems appropriate:

You and I are going for a picnic in the jungle. Talking happily we arrive at a pretty spot and spread our napkin. Suddenly you catch sight of a tiger crouching ready to leap in a nearby bush. We have no fire-arms with us. There is no tree to climb. What would you do? Well, you would go deathly pale. Your heart would palpitate violently. Your mouth would go dry. You would be paralysed by fear, you would tremble, you might even faint or soil your clothes.

Under such circumstances can you eat, can you

sleep, can you make love, are you in full possession of your memory and other intellectual powers, can you concentrate on anything other than your fear of the tiger? No! Of course, you can't and no one can blame you. Nor, incidentally, does it enter your head to believe that your pitiable state is due to a sudden illness.

Now to your horrified surprise you see me showing no signs of fear whatsoever. In the presence of this angry tiger you see me smiling and contentedly munching a sandwich. Shocked you whisper to me, calling my attention to the tiger. I casually assure you that I know the tiger is there. You come to the appalling conclusion that I have gone insane. In this you are confirmed when you see me get up and walk straight up to the tiger and with a light push bowl him over. Then I drag him out of the bush into the open and as I call to you to come over and have a good look for yourself you suddenly realise that the tiger was only a stuffed hide.

Now the only difference between you and me is the fact that I know the tiger to be a stuffed one while you did not know this. From the moment you shared this knowledge your "dis-ease" vanished. You feel a bit embarrassed about having been had. You are possibly a bit annoyed with me for having made a fool of you but soon a healthy appetite supervenes and you heartily join me with the cake and sandwiches.

We are here concerned with visible tigers, fears of which you are conscious though you may not associate them with your bodily symptoms. We are not concerned with abstruse phobias where the tiger is hidden in a dark, matted bush or where there is

not even a vestige of a tiger. To rummage around in dense emotional shrubbery, to stalk the beast and bring it to light, that is the psychiatric specialist's job, not that of the patient for he might encounter a real tiger and get his emotions severely mauled.

The average patient is not sufficiently at home in the jungle of the subconscious mind to attempt any big game hunting.

A large part of psychosomatic trouble is contained in the story of the tiger. It is good to enlarge upon those symptoms of which you complain, so that you realise as clearly as possible that fear alone, not necessarily organic illness, can account for them.

Unfortunately, some doctors do not appreciate the importance of the tiger. They often adopt one of two possible attitudes, either they say that the patient is talking nonsense; that there aren't any tigers in this jungle and that there is nothing to be afraid of. Or they do not see that the patient is only terrified, they interpret the symptoms as an organic disease.

The latter attitude is understandable if the patient does not confess to fear and does not say what he sees in the bush. If the physician does not bother to have a look round he will naturally be surprised at the violent reaction of the patient's body and feel obliged to find an explanation in disease.

This results all too easily in a heart-stomach-dopetonic-flavouring mixture with which he tries with one fell therapeutic swoop to conquer a whole pathological museum of diseased organs. He is in the same position as any physician would be if he encountered a case of sea-sickness on dry land. He, as well as the patient, would be hard to convince

that they were not dealing with a major abdominal emergency. When the same symptoms occur through the centre of equilibrium trying to counteract the movement of a ship, no one is seriously alarmed, not even the patient, in spite of acute discomfort, simply because he knows why.

Once the patient suffering from a psychosomatic disorder grasps the overwhelming importance of fear and can then be shown that there is no cause for alarm, rational treatment becomes possible; though this does involve the trouble of getting up and incontrovertibly demonstrating that the tiger is a dummy. Merely affirming this to be the case from a comfortable position at the picnic is quite ineffectual. The patient requires real proof, for to him the tiger is real. Until he can come up and handle the taxidermal masterpiece himself, convince himself, and laugh at himself, he will not be convinced.

Often there is a compulsion about fear. The patient says: "I'm terrified of cancer, I know it is silly, but I cannot help it." Here again the psychiatrist will probe deeper. He will regard cancerophobia as the expression of a conflict, a mal-adjustment. To him the emphasis is on *phobia* while for us the emphasis is on *cancer*.

Such a patient can only be helped if his doctor explains the classical symptoms of cancer in such a way that the patient feels his suspicions are being taken very seriously, while he is left to discover for himself that none of his complaints tally with the symptoms of real cancer. The patient must not be bludgeoned into the conviction. He should not even be persuaded. He must reason it out for himself.

The approach should be: "Well, let's find out if it is cancer." Not: "Pooh-pooh! Of course, it isn't cancer."

It is surprising how many patients are benefitted merely by having their attention called to the connection between an existing anxiety and their symptoms, even if the anxiety as such is not brought to light.

Every psychiatrist is familiar with the initial difficulties of getting a patient to talk freely and honestly. The reason for this reticence is not necessarily a hidden complex, it is just as often simply shyness in which case the patient knows exactly what he should say, if he were frank; he is fully conscious of the nature of his anxiety, though he cannot bring himself to mention it. It is a conscious repression. The subconscious mind has nothing to do with it and does not, therefore, require to be unravelled.

A good physician can very often convey the impression to his patient that he knows what is causing the fear and apprehension without receiving any confirmation from the patient. This makes his explanation of the bodily symptoms just as effective as if he actually did know. The patient feels that he understands exactly what the doctor is driving at and he weighs subsequent discussions in that light, much to his advantage.

As a general rule one may assume that where the fear concerns a purely bodily misfortune, such as disease, impotence, pain, invalidism, etc., there explanations alone will achieve lasting results. Where the fear concerns a rational emotion, such as the fear of death of a beloved one, estrangement

or unfaithfulness of a sex partner, economic ruin, the burden of unaccustomed responsibility, etc., there good results are possible, but not certain, with instruction only. Where the fear concerns an irrational emotion, such as the dread of mice, snakes, germs, a crowd, fire, burglars, nightmares, fear of being shut in, etc., there explanation alone will rarely achieve lasting results. In such cases, the aid of a psychiatrist should be sought.

Now let us look a little more closely into this powerful emotion—fear, and into the bodily repercussions it produces.

Man is descended from animals which found that in the struggle for life, avoiding their enemies, or, if need be, running away from them proved far more satisfactory than fighting them. Those that could run fastest lived longest and so among our animal ancestors there grew a selection towards more efficient means of escape. Even today when our ingenuity has placed in our hands powerful weapons with which we can overpower our natural enemies, our body still reacts to danger with those prehistoric mechanisms which *homo simplex* made use of before he became *homo sapiens*.

To a bull courage is natural, he reacts to danger with rage. We react to it with fear. That is why we reward courage and heroism with a medal; not because it is biologically natural or sensible, but because it is a triumph of the will over natural reflexes. It impresses us because it is unnatural and abnormal. If bulls were in the habit of distributing medals among themselves they would decorate the ones that mastered their rage and with un-bullish agility dodged and frustrated the infuriatingly red

matador. We, on the other hand, would have little admiration for such a bull because he would be doing just what we all would do if we followed our instincts.

Far from being despicable fear is one of man's greatest assets. For one thing it has sharpened his wits. Fear of hunger and poverty makes him work. Fear of destruction such as in war stimulates his inventiveness. Fear of disease and death has fostered his medical science. In fact, man is at his best when he is scared.

When the brain decides to be heroic—which it only does when the odds for survival appear fairly reasonable—the body is at a loss how to prepare itself for the emergency; but when the brain decides upon flight the automatic regulations know exactly what to do. The trouble is that our body is not suited to generate blind physical rage like the bull who cannot help hurling himself at destruction, regardless of odds, once he is roused. What we call rage is not the grand rage of the big cat wounded. Our rage is a petty thing, invariably directed at a minor danger, annoyance or inconvenience. We are not furious with a charging rhinoceros, we are terrified.

It is obviously no use trying to gloss over these facts. We have got to reckon with them, otherwise we get into that very muddle which lies at the root of so much psychosomatic suffering.

Our body, helpless when instructed to be brave, is magnificently co-operative when instructed to prepare for precipitate flight. It stops all unnecessary or encumbering activities, such as feeding, digesting, sleeping, sex, abstract cerebration and

leisurely contemplation. It can even empty the bowel by a sudden burst of diarrhoea and involuntarily empty the bladder to make us lighter for the flight. It changes into top gear breathing, circulation, muscular tension and sensory activity. We become supercharged. That is why we can run faster for our life than for an athletic championship. That is also why we can scramble up a tree much faster when chased by a mad dog than when we are bird-nesting, however much we may have practised such activities.

Now the point at which things go wrong is this: the body and its automatic regulations have no idea that we are equipped with guns, motorcars, air-raid shelters and policemen and that not every time he is frightened does man have to run away, that is, use his muscles for maximum exertion. So the old-fashioned body goes on preparing for a sprint which never comes off. This leads to palpitation, trembling, a cold sweat, symptoms which would never manifest themselves if we did actually run and thereby make the normal physiological use of this sudden nervous stimulation. But we do not understand these strange and apparently useless symptoms and invariably misinterpret them. We take them to be the forerunners of disease while, in fact, they are healthy and normal reactions to fear. Thus, the body's response to danger, real or imaginary becomes in itself a new source of anxiety. Again we have that vicious circle.

A known danger is much less terrifying than a vague unknown one. Undiagnosed abdominal pain can produce far more trepidation than a downright appendicitis. Pneumonia is less frightening than a

persistent little dry cough, caused by an irritated throat, but believed to be incipient tuberculosis.

We have all experienced listening intently to a peculiar noise in the silence of the night and wondered what it might be. The nervous person will let his imagination run wild. To him it is the crackling of a fire, perhaps a burglar or maybe the homicidal maniac yesterday's newspapers wrote about. Wild stark terror clutches at his heart. The risk of investigation becomes so great that silent prayer for deliverance is the last and only refuge.

The emotionally robust experience no such agonies. They curse the disturbance in their sleep. Switch on the light, fish the stagbeetle out from behind the grandfather clock and throw it out of the window. In a matter of seconds they are fast asleep again.

The psychosomatic patient usually behaves like the nervous person that he is; but even he can be relieved if someone else proves to him that it was only the small stagbeetle that was making so much noise, and that there is nothing to be frightened of. But he must be shown the stagbeetle.

Thus, we see that without a frank, objective and honest approach to the phenomenon of fear it is impossible to deal with psychosomatic troubles.

CHAPTER VI

By Tampering with a Clever Gadget

POSSIBLY the most reliable ally in our struggle for existence is the perception of that remarkably unpleasant sensation which we call pain. It protects us against the incessant assault from an inhospitable outer world, and does so far more efficiently than would a coating of armour plating such as lobsters, crabs and beetles have gone in for. We need only think of the weight and clumsiness of such a contraption and how badly we would miss the joys of tender touch, to be thankful that nature devised pain as a better solution to the problem.

Without the sense of pain life would be impossible. We would tear our hands and feet to shreds. Unnoticed thorns would fester in our flesh and normally painful disease would progress beyond repair before we felt an urge to attend to it. Pain makes us rest a fractured limb and forces us to nurse a wound. It compels us to shrink from fire or an injury before it can become serious. It does all that in the new-born babe, as well as in the idiot. It functions perfectly without supervision from the reasoning brain, and yet it does often trouble the mind as we shall see.

Apart from the fact that in the perception of pain as a disagreeable sensation the threshold of consciousness plays an important and obvious role, it has another aspect which is responsible for much psychosomatic suffering.

Take for example the patient who has sustained

a severe injury and has fractured his thigh. He has excruciating pain but once safely in the hospital ward he can force a smile and ask the nurse for a cigarette. When the surgeon showed him his x-ray he gasped a bit when he saw the havoc in his leg but as the doctor did not seem unduly perturbed and went about fitting extensions, plasters and weights in a confident business-like way, the patient accepted his pain as an inevitable nuisance, made light of it and was soon able to lead a reasonably cheerful existence in spite of his awkward confinement and helpless immobilization. He fully understood why he had pain, indeed he wondered why he did not have more considering the mess his leg was in.

A patient who has had an operation which was successful expects the wound to hurt and is usually prepared cheerfully to put up with his pain. Women desperately anxious to have a child fortitiously stand the labour pains and actually feel them less than those who are terrified or look upon child-bearing as an unwelcome interruption of their usual social activities.

Now let us look at the others, our psychosomatic patients. They have a *queer sensation*, a *peculiar ache*, a *funny sort of pain* for which neither they nor their family doctor can find an entirely satisfactory explanation. This is somewhat perturbing and when various mixtures, injections and tablets bring no relief the perturbation grows into panic. The little ache swells into such intolerable agony that many an unwary surgeon has been bamboozled into doing something with a knife which he shouldn't have done.

Now there is one almost universal misconception about this sort of pain. A misconception shared by well-meaning friends and, sad to relate, some doctors. It is a doubt as to the reality of the unpleasant sensations the patient complains of. Such doubt causes endless mischief by hopelessly confusing the patient who knows perfectly well that he is not *imagining things* and that it is a fatuous and absurd suggestion from his would-be advisers that he should *just take no notice of it*. In this the patient is for once completely right and his smug councillors utterly and hopelessly wrong.

It is high time that it becomes generally known that there is no such thing as an imaginary pain. With the possible exception of advanced lunacy it just does not exist. Whenever and wherever there is pain of any degree there is always a physical reason for it. Our brain never under any circumstances whatsoever registers pain without a very real reason for doing so. This does not, however, mean that pain is always due to disease. It is just that which causes the confusion. Some people seem to find it impossible to understand that an anatomically healthy organ can cause excruciating pain and that when we operate under anaesthesia and find nothing abnormal that does not mean that the patient has been cheating us.

The mechanical power inside our body is provided partly by the skeletal muscles which, for instance, we can use in breathing, but chiefly by an entirely different type of muscle—smooth muscles we call them—over which we have only very limited and indirect control. They are managed by the autonomous nervous system. Now an excessive

distention or an excessive contraction of these smooth muscles is painful. Abdominal gripes are due to violent contraction of the muscles which form the wall of our intestines. The painful sensation often associated with flatulence is caused by an excessive distention of these muscles. In the same way a distended bladder can become very painful yet neither the bowel nor the bladder are necessarily diseased. Such examples can be endlessly multiplied. We shall meet many more in later chapters. The thing we must here understand clearly is that the presence of pain in the absence of all other signs and symptoms of disease is still a very real pain.

The patient has a right to have the cause of his suffering explained to him and that is exactly what this book sets out to do. He has a right to be lifted out of the category of troublesome liars who need some dope to keep them quiet, into the category of unfortunate sufferers who have in the past been grossly mishandled and for whom science is only just beginning to provide relief.

As we have already seen, anxiety, constant attention, apprehensiveness and fear are the emotions upon which psychosomatic suffering thrives. Little wonder, therefore, that a small pain for which no satisfactory explanation is forthcoming grows into a big pain, a little worry about it into an all-engulfing preoccupation leaving neither room nor time for any useful activity and completely destroying the joy of life.

Let us think back to our fracture case; he too suffered intense pain, but it never got the better of him simply because its origin was fully clear to him and self-evident. If we can succeed in making the

cause of the psychosomatic patient's suffering equally clear and self-evident, he would be able to put up with his malaise with the same ease and happy confidence as the fracture case. Luckily for him there is usually no need to put up with anything at all, for the moment he feels really and completely re-assured, his complaint vanishes as if by magic which is considerably more than mere jollity will do for a broken thigh bone.

Thus we see that while pain is normally an ingenious evolutionary device for maintaining our health and safety, our all-too-inquisitive brain, untutored in the ways of the body, can sometimes turn it into a menace. Deft handling of the situation can avoid a catastrophe, but clumsy bungling of the Oh-you-are-only-being-neurotic type is apt to precipitate a calamity.

Pain categorically demands respect; if it did not it would be useless. It will always achieve its object. The body always wins. If this were more generally appreciated, pain would always be given the explanation it demands, instead of being intensified by futile efforts at arguing it away. The happy result would be that many of our psychosomatic patients would be saved the indignity of wallowing in their, to them incomprehensible, misery.

P A R T II

THE SIMPLE WAY IN WHICH WE GET THE BETTER OF OUR NERVES

CHAPTER VII

Constipation and the Rectal Ritual

HABITUAL or more alarmingly called chronic constipation is a psychosomatic disorder and nothing else.

It is probably the most widespread of all psychosomatic disorders. Possibly more money is spent on its alleviation than for the treatment of any other known ailment. The nervous energy dissipated by its victims may be prodigious. Yet it can be permanently cured in usually less than a week by a careful explanation of what is really happening. The success of this method is almost one hundred per cent. For these reasons habitual constipation ranks first among the psychosomatic disorders with which we are here concerned.

Defining habitual constipation we can say that the term does not apply to cases in which there is a detectable, mechanical stricture or obstruction caused by an anatomical abnormality. We do not consider a person as *suffering* from chronic constipation who normally has a motion once in three days or even once a week as long as he is healthy, well and perfectly satisfied with his slow rhythm. Such

a person usually has the good sense to accept the position cheerfully, to resist all therapeutic blandishments and to treat such medical bogeys as *intestinal toxæmia* and *putrefaction* with the lusty contempt they deserve in a case such as his. Obviously we do not include in our discussion cases in which there is a sudden and recent interruption of an established rhythm as may be the case in an acute organic or infectious disease.

Thus then, our term applies to that vast contingent of people whose suffering ranges from a mere intestinal *sluggishness* for which they take a *little daily dose* or *aid to digestion*, to the person who is driven frantic by the fact that even the most violent purging will not bring about the desired result. Somewhere between these two extremes lies that group of patients who have one or several motions a day, but are harassed by the conviction that these motions are entirely unsatisfactory.

Strangely enough, and we may say fortunately, the condition which is responsible for all variegated symptoms associated with or attributed to habitual constipation can be summed up in the few words that it is nothing more nor less than an abnormally *empty gut*.

Such paradoxical generalization needs explaining.

Two misapprehensions lie at the root of chronic constipation. The first is a totally unfounded notion that unless a copious stool is evacuated once or even twice a day, there must be some serious obstruction. The patient is unaware of the scientific fact that the quantity of stool passed is not directly related to the quantity of food eaten, but depends to a far greater extent on the bacterial growth in

the large gut and on the water content of the stool.

When suffering from habitual constipation, it never spontaneously occurs to us that our small stool may be the simple result of the fact that our lower intestine just does not contain more. We fear an obstruction and confirm our fears by a second misapprehension, namely, that our abdominal distention is caused by a blockage with stool, by being, as we say, *bunged up*. We do not realise that our *heaviness* and *gases* are caused, not by decomposing faecal masses as we think, but that they are the inevitable result of cramps in our *empty* gut or colon, as we call the large intestine.

Now, as long as we labour under these erroneous notions we necessarily choose the most irrational method conceivable to put matters right. We will do just those two things which we should scrupulously avoid, namely, purging and eating less food.

If we understood the mechanism involved we would refrain from attempting to have a stool for several days and eat *more* than our normal quantity of food which, if done with the happy confidence that this is the right thing to do, would in a few days completely relieve our distressing emptiness, our spasms, gases, pains and indigestion. Moreover, we would enjoy the satisfaction of a regular, quick, smooth, easy and ample evacuation.

That is the idea on which the cure of habitual constipation, merely by explaining, is based.

When we suffer from what we have been taught to call constipation our whole day is coloured, our comfort and our happiness is made or marred by what takes place in this secluded secrecy of our water closet.

Here are some of the things the detached eye of science prying into this secrecy, would find. It would see an unhappy mortal crouched on his seat in a pose reminiscent of Rodin's statue, "The Thinker." And thinking, thinking of his misery, is just what he is doing. After a while he succeeds in passing a tiny quantity of normal stool. But with this he is not satisfied. With swelling hope he now gets a sensation that there is lots more to come. So he tries desperately to get rid of this, as he thinks, accumulation *ante portas*.

To achieve this happy result he will go on straining for a quarter, even half an hour, though he knows from sad experience of the past that his efforts are doomed to fail.

At last he may succeed in getting rid of a little bit of semi-solid stool which is at least something, though nothing like what his feelings had led him to anticipate.

This fiasco leaves him listless and depressed. Very soon his headache will start. His meals will be a miserable compromise between his hunger and the conviction that every bite he swallows will add to the embarrassment of his already—as he thinks—overloaded bowels. Crushed and humiliated he refuses his breakfast and, over a cup of black coffee, scans the morning paper for the latest thing in salts, oils, pills and medicated chocolates.

During the whole day, he will watch carefully so as not to miss the faintest *call of nature*. The smallest wind, travelling down his gut, will precipitate a dash to the lavatory in the vain hope that this may be an opportunity to relieve himself of a little more. It is a vain hope, but he would not dare

to forego the chance. He is indeed a wretched mortal.

Now to the watching scientific eye the whole thing is nonsense from beginning to end. The brain gets hold of a stupid notion and then becomes exasperated because the body cannot and will not join in this purely intellectual caprice. By way of illustration I will describe an identical situation which you will at once recognise as farcical.

Let us suppose we have succeeded in convincing a man that it would do his brain a world of good if he knocks his forehead hard twenty times against a brick wall, every morning, before his bath and that if he fails to do this his brain will rapidly deteriorate. Now if the poor victim of our persuasion scrupulously follows our advice he will very soon have to consult a doctor for an ugly, septic patch on his forehead. His daily performance has grown intolerably painful. Foolishly thinking his antics are normal and common to all, he omits to mention them to his doctor. The doctor, on the other hand, has no idea of what absurd tricks the patient is up to. He, therefore, treats the case as a skin disease and cannot understand why the blessed thing won't heal. Doctor and patient, both earnestly labouring to do the right thing, are soon driven frantic.

Then one day a friend shares the patient's room and to his horror sees the head swathed in bandages being banged against the wall. He exclaims, "Good God! What on earth are you doing?" To which the patient replies casually, "Why, giving my brain its morning exercise of course." There follows a heart to heart talk. Within a week the skin disease has healed and all is well.

The cure of habitual constipation is just as easy provided you have a good friend. In what follows you will find him.

At the end of the book, there are two diagrams, Figs. V and VI. Fold them out and keep them open while you read.

Fig. V shows you what a normal colon, that is the large intestine, of a person who never suffers from constipation looks like. The colon, as you know, begins in the lower right-hand corner of your abdomen near the hip bone. It then reaches up underneath the liver and goes across to the other side in a loop to the spleen and from there it descends to the left hip bone, continues with a further loop called the sigmoid to the rectum from where the stool is evacuated.

In a normal person this colon is, as you see, completely filled. It has a diameter of at least two inches all the way along and the lower end, the rectum, is filled with faecal matter ready for evacuation.

In every normal colon gases occur as the result of a healthy process of digestion. When such gases form in the colon of a normal person, not suffering from constipation, they can move freely upwards and downwards or they can split up into small gas-bubbles which find their way through the length of the colon. When they reach the rectum they are passed as a wind. A person with such a normal, healthy colon passes wind ten to twenty times a day, according to some extent to the type of food he eats. Passing such winds is a perfectly normal part of digestion and elimination. You can see these gases in the diagram.

When this normal person goes to stool once a day he empties only the lower part of his intestine, the cross-shaded part below the line in the diagram, and thereby produces an ample, formed stool as shown beside the colon. Such a normal stool is usually evacuated in about thirty seconds. After this evacuation the normal person has the very comfortable feeling that he has passed all the stool he needs to pass. Such an evacuation is extremely satisfactory. During the next twenty-four hours more colonic contents move down and fill the lower part.

There, the consistency becomes more solid through the resorption of water, digestive juices which have been most liberally secreted in the upper intestinal tract and the absorption of a certain amount of nourishment which has required a lengthy process of digestion. This absorption is shown by the row of arrows in the picture.

You know that food can very well be absorbed from the lower part of the intestine because you have heard that it is possible to feed a person by giving him food in the form of an enema. It is particularly the proteins and some of the vitamins that are not assimilated until the food has reached the lower end of the colon where the process of digestion is finally completed.

You will, therefore, understand that it is very important that this lower part of the intestine remains full long enough for a complete absorption of food from the intestinal contents. If the stool is passed out too soon a lot of valuable nourishment is lost because the body has not been given sufficient time to absorb it.

Now look at Fig. VI. This is a picture of what

your intestine looks like when you are suffering from what you call constipation. You see that, compared with the normal intestine, your intestine is very empty. The bulges that you see in this picture are not, as you may think, filled with faecal matter. They are distended by gases.

The difference between your intestine and the normal intestine is only that in your case the gases cannot pass freely along the whole course of the colon because these distended areas alternate with others which are empty and cramped. This cramp prevents the gases from moving on, so they blow out your intestine. That is what we call flatulence. The squeezing of wind from one ballooning to the next through the narrow intervening portion produces those familiar rumblings, commonly known as *colliwobbles*.

Now when *you* go to stool, you will pass immediately only a very small quantity of normal stool as shown in the diagram. This is all you have a right to pass because in your contracted gut there is no more available. But when you see this small quantity you have a notion that this is not nearly enough considering the amount of food you have eaten. You are confirmed in this notion by two further facts.

We have very powerful ring-muscles round the end of our rectum as shown in Figs. V and VI. In a normal person these muscles are in a state of semi-relaxation, but when a colon is spastic and empty like yours, these ring-muscles are tense, tight and contracted. The contraction of these muscles gives you that unpleasant feeling that, after you have passed a small quantity of stool, you still have a lot

of stuff left behind which you must, under all circumstances, try to get out.

This feeling of being full-up is, of course, not due to actual filling. It is entirely due to the cramp of these ring-muscles. If you don't believe me—I admit that the feeling is so real that it is hard to believe—you can easily convince yourself by inserting a finger into your rectum. To your surprise you will find that instead of being full of faecal matter, as you suspect, your rectum is entirely empty.

Now as you have a feeling that there is a lot more to come, you start straining hard and long, which to your distress, does not yield the expected result but merely, after some time, produces a little semi-formed stool. You will regard this as highly unsatisfactory, but as it is better than nothing you finally give up in despair and decide that you had better take a larger dose of medicine so that that big mass you believe to have felt can be successfully disposed of. When the laxative produces nothing other than a little brown liquid you become very perturbed, thinking all the while that there must be a mass obstructing your colon when in actual fact there is, of course, no such mass, but merely, a cramp of certain muscles which produces the delusion.

When finally, after a long session of straining and exertion, you do pass some loose motion, this does not come from the lower part of the colon as it should do. It comes from what we call the descending colon, that is from much higher up. It is all stool which should not have been evacuated at all; it is matter in which the process of digestion has not yet been completed and which should have been kept inside your colon for another twenty-four hours

so that digestion and resorption of moisture can take place completely before it becomes really only such waste matter as the body evacuates having no further use for it. By straining and emptying this loose stool from higher up, you are continually depriving your body of food and digestive juices and, of course, increasing the abnormal emptiness of your intestine which in turn leads to cramps. These prevent the gases from moving freely up and down so you get the distention shown in Fig. VI.

The person whose colon is in the normal condition has, strangely enough, a feeling that his inside is perfectly clean and empty, whereas in fact it is completely filled as it should be. You, on the other hand, have a continual feeling that your intestine is full, whereas it is, in fact, abnormally empty. This feeling of fullness is produced by the localised areas distended with blocked gases. You see, from the illustrations, that the diameter of a normally filled intestine is much smaller than the diameter of your intestine which is empty. This distention gives you that feeling of fullness which you erroneously ascribe to constipation, that is, a blockade of the contents of your intestine. It is merely the result of abnormal emptiness which allows the intestine to contract in parts and thereby give you pain and discomfort.

The problem we have to solve is to change your abnormal colon which looks like Fig. VI into a normal colon like Fig. V.

That should not be difficult.

Your colon is a pipe which is open at both ends. If we want to fill such a pipe it is obviously necessary to close one end and put more into the other.

Translated into terms of the large bowel this means that you will have to refrain from having a stool for several days and eat more than your usual food until your pipe is completely filled. This takes about three days of hard feeding without having any motion at all. It is surprising how much room there is in our colon and how much food must be eaten before an entirely empty colon can be changed into a normally filled one. It is only necessary to eat this large quantity of food until your intestine has been properly filled, thereafter you can, of course, return to a normal diet.

You see now that you have been labouring under a misapprehension. You have tried to cure yourself by having more motions with the help of laxatives; in other words by producing artificial diarrhoea. Because you feared that there was already too much stool in your inside, you have refrained from eating. Now you understand that this is exactly what you should not have done. The cure for what you call constipation is obviously to have *less* motions and to eat *more* food, not as you have hitherto been doing, trying to have *more* motions and to eat *less* food.

You are now thinking that to refrain from having a motion for three days is very terrible advice. Your mother taught you, and very rightly so, to have a motion every day, so that a regular habit would become established. Your mother was, however, not concerned with whether this would be possible if you reduced your diet and resorted to artificial methods of emptying your intestine. There is nothing to be terrified about.

We consider a perfectly normal function of the

human bowel to be an evacuation once in twenty-four hours upto once in three days. Three to four evacuations per day are decidedly abnormal. There are many people who have a very much slower rhythm. Some people empty their bowels once a week, yet live a perfectly healthy life and eat a normal amount of food in spite of this habit. I am not suggesting that this is entirely normal or usual, but it does show you that such a habit is quite compatible with healthy living.

You have nothing at all to fear from refraining from emptying your bowel for a few days until it regains its normal filling. In fact, one can say that it is very much better to attempt to keep your bowels full than to attempt to keep them empty.

The human bowel was not meant by nature to be kept empty and clean, it was meant to be kept full, otherwise it would not have developed in the way it has. If nature intended the bowel to be kept empty, we would not need to have a bowel at all. The facts are that the colon performs a vital part in the process of digestion, that it can only perform this function when it is normally filled and that its contents are not, as you are possibly imagining, a mass of decaying putrid matter. The contents of the colon are chiefly food, which does not change into the waste matter which we eject until it has reached and remained in the lowest portion of the colon for about twenty-four hours.

Under normal conditions, that is to say, in the absence of poisons or an infection with disease-producing germs, there is no putrefaction or decay in your bowel. Though you may not believe it, you have never in your life had a real obstruction. A

mechanical obstruction of the bowel is an extremely serious condition which nearly always calls for a major surgical operation. It is never caused by *constipation*.

Now let us assume that for three days you have followed my advice, you have taken no form of opening medicine and have tried to avoid going to the bathroom, which, as you considered yourself to be hopelessly constipated, should be very easy. Furthermore, you have been eating a larger bulk of food than you normally do and we may assume that by the morning of the fourth day your colon has reached an approximately normal degree of filling. You will, therefore, on the fourth morning go to the bathroom and give yourself exactly thirty seconds by your watch. If during those thirty seconds you pass a stool, well and good. If you don't it does not mean that you are suffering from terrible constipation, it merely means that you must eat a little more and wait another day after which you will surely have a perfectly normal stool such as you have not had in years.

Let us suppose that everything has gone according to schedule which it certainly will if you go about it without any undue anxiety or fear. Do not worry about the discomfort, headache and the loss of appetite, which you anticipate. I can assure you that the loss of appetite and your headache are both due, not to the fact that you have not had a motion, but simply to your own apprehension about not having had a motion. It is your fear, your anxiety and your dread of impending consequences that produce these common symptoms. If you believe what I have explained to you and go about the

thing in an understanding and calm way you will, to your surprise, have none of the symptoms you dread.

From now on you must make it a rule to go to the bathroom every day at a fixed point in your daily toiletry routine and not just at any time when you feel the urge. The human body very rapidly learns to adapt itself to a fixed schedule. That is why so many people who have normal motions will tell you that they never bother about their stool at all. Every morning they either drink their cup of tea or smoke their cigarette and then everything moves like clockwork. This is because their body adapts itself in such a way that when smoking the cigarette or drinking the glass of water or whatever their ceremony may be, has been performed, the evacuation begins to function automatically.

I remember once having had a patient who delightedly assured me that she had discovered an unfailing remedy for constipation which was to eat three spoonfuls of jam on an empty stomach after which her bowels would function without the least difficulty. It was, of course, not the jam that acted as a laxative, it was merely the fact that her body knew that after the little ceremony of jam-eating the next thing would be the evacuation. It is, therefore, very important that you always go to stool at the same phase of your daily routine. Where you place the evacuation in this routine is of no importance, just as it is of no importance what the time is by the clock. It is the habitual sequence of events which is the important thing. The conditioning of the automatism as those who have studied Chapter IV carefully will call it.

When you go to stool you must now make it a rule never to sit longer than thirty seconds. The human bowel is constructed in such a way that it will always evacuate all it wants to get rid of within thirty seconds. Anything passed after thirty seconds is certainly in excess of what should be passed. It is stool which comes from very much higher up in the intestine and which is not yet ready for evacuation. Any urge to pass a further stool should, therefore, be suppressed and if this is done for a few days, the urge will disappear completely. You will enjoy the healthy satisfaction of passing an ample stool within the prescribed time.

Once you have a clear conception of how important it is to keep your colon normally filled, you will no longer be alarmed if occasionally, when you go to the lavatory in the usual way, you do not pass a stool. That will not arouse in you any terrifying suspicions that you are again suffering from constipation. It will merely be an indication that you are not eating a sufficient quantity of food to have a daily evacuation.

There may be many reasons why your intake of food becomes temporarily limited, such as for instance, when you have a bout of fever or other illness and you do not feel inclined to eat normally. When that happens you cannot expect to have a copious stool every day and you must be satisfied either with a very small daily quantity or a larger stool on alternate days or at even longer intervals. That is nothing to get alarmed about. If your doctor should consider it necessary for you to take an enema as may be advisable in the course of some illness or may have prescribed for you a laxative you will

henceforth understand that after such a forced evacuation you cannot possibly expect to have a normal stool twenty-four hours later, that it will take a few days of normal feeding until your colon has again filled up.

It is a good rule to pay as little attention as possible to the evacuation of the bowel. Suppose I ask you how many times you have passed urine during the last twenty-four hours. What was the colour of this urine? Was the quantity in what you consider the right relation to the amount you had to drink? What sensation did you experience while actually passing the urine, etc.? You would not be able to answer a single one of these questions. If I ask you similar questions concerning your morning evacuation you would probably be able to tell me a long story with explicit detail. This is because your attention is fixed upon the evacuation, whereas it is not apprehensively fixed upon the passing of urine.

It is, as we have seen, very bad indeed if the brain keeps supervising the automatic functions of the body. Your bowel can look after itself very much better than your brain can look after it.

Your bowel and its functions have a long history of evolution spread back for millions of years. It is a much older organ than your brain. Though your brain has undisputed authority over your bowel, it has little technical knowledge of how the elimination of waste matter is achieved. Your bowel, on the other hand, knows its job perfectly and you would be well advised to discontinue allowing your brain to tinker with organs it does not understand.

We must not be at war with our bowels. We must

adopt a friendly attitude towards them and stop bullying them. The relationship between our brain and the bowel is that of a master and his servant. Our bowel is a very good servant, but if we treat him badly he will not give us as good a service as we could get if we treated him more kindly. We must have no attitude of anger, a feeling that our bowels are not obeying our wishes. That is entirely wrong. We must go to stool completely relaxed, mentally and bodily. Our attitude should be one of questioning our bowel politely whether it has any waste matter it wishes to discard and of giving it an opportunity to do so. When we are mentally tense, the ring-muscles round our anus will also be tense and as these muscles are not under our voluntary control they cannot be relaxed at will. When they are taut, then no amount of straining will ever enable us to pass a stool. These muscles are much too powerful. They are about as strong as a clenched fist. The way to unclench these muscles is to be mentally at ease and not to attempt evacuation with the unpleasant anticipation that we are almost sure to be in for a disappointment.

Are you now convinced that what I have explained to you does actually cover your symptoms and is a true description of what you are suffering from? Do you feel that by following what I have explained to you, you can re-establish a normal functioning of your intestines? Do you realise now how simple it all is and that all your troubles come from entirely mistaken ideas? I am sure you do.

Occasionally a laxative addict has a dread that if he does not pass a stool for three days a very hard, stony mass will form. In such cases it is well to

take plenty of water, to eat a very bulky diet and to rest assured that such food will not harden in the intestines because it retains more water. A hard dry stool is always the result of an insufficient intake of water. Our body, consisting of about 60 per cent of water, needs extra water to moisten the breath, to sweat, and to prepare urine. The body will go to any length to get the water vitally necessary to maintain these functions; even to the extent of taking it, as a last resort, out of the blood. Normally it gets it out of the intestinal tract. It is especially efficient at extracting water from the lower end because there moisture is not as essential as it is higher up. Thus when the body needs more water than is supplied it covers the deficit from the rectum. The result is a hard, dry stool.

It should now be clear that *constipation* is not primarily a disorder of the large gut. It is primarily a nervous complaint caused by our brain trying to be too clever. It has nothing to do with our diet, our sedentary habits, the climate, nature of the water, lack of exercise or any of the other reasons its victims are so prolific at thinking up. It is a misunderstanding and nothing else. Once the misunderstanding has been cleared up it never occurs again. The cure is lifelong.

CHAPTER VIII

The Diarrhoea of Fear and the Fear of Diarrhoea

WITH only the rarest exceptions habitual constipation is a complaint of nervous origin. In the case of diarrhoea there are many diseases of which it may be a prominent symptom. It may be due to one of many possible infections, inflammations, or certain forms of malnutrition.

Such cases do not concern us here. We are only interested in diarrhoeas for which the doctor can find no really satisfactory explanation. They are much more common than is generally believed. Such patients are often treated for something they have not got. The result of such treatment is that the diarrhoea gets worse.

Modern medicine has the means to deal satisfactorily with most infections and all malnutrition. It is when these methods fail, that we must look to the nerves for the cause of the trouble.

Sometimes it is easy to recognise nervous diarrhoea. Take, for instance, the case of Mr. A., a middle aged banker who liked his golf. Here is his story:

Since about six months he had had to give up golf for a reason which seemed to him so "stupid" that he could not bring himself to see a doctor about it. His "stupid" complaint was that every time he reached the eighth hole, the one farthest away

from the pavilion, he got an uncontrollable attack of diarrhoea which forced him to make a dash for the nearest bush. He never had diarrhoea as long as he kept off the links and the morning after such an uncomfortable incident he always had a normal stool, perfectly formed. He discovered to his amazement that if, on a solitary round, he skipped the eighth hole all was well. He disliked solitary rounds; he wanted a match. But how could he explain to his opponent that there was something spookish about the eighth hole; that he was frightened of it and must avoid it at all costs. So he had reluctantly given up golf and started billiards. He eventually consulted me because he preferred exercise and the open air to his club.

"I know perfectly well," said Mr. A., "that this is sheer nerves, but somehow this knowledge does not help me to get over it."

It was a very easy job to return Mr. A. to his beloved golf-links. He had made the same mistake so many psychosomatic patients make. He had been frightened of thinking backwards. It was clear that something must have set this undesirable automatism off. So we spent half an hour raking back in his memory. This produced the clue.

One morning Mr. A. had not been entirely satisfied with his morning stool so he—unwisely as we have seen in the last chapter—took a *dose* before he went to office. In the course of a busy day he forgot all about it—he was not a regular purge addict—and so when Lady B. rang him up and asked if he would do a round with her, he delightedly accepted. The match progressed satisfactorily, but at the eighth hole he was suddenly

caught short. There was nothing for it but to stammer some dithering excuses and run. When he emerged from the bush, looking rather sheepish, Lady B. was waiting for him and tactlessly said she hoped he was feeling better. For the rest of the round his performance was so atrocious that Lady B. was several times constrained to enquire: "What is the matter with you today?"

Altogether it had been a horrible experience, indeed, so horrible was it that Mr. A. had never dared to think of it again. He had suppressed the memory of it; hidden it in his subconscious mind and barricaded its path to his consciousness with an impervious array of incorruptible censors. He had completely forgotten the incident until in the quiet safety of my consulting room we brushed the censors aside and made him spill the beans. The following day he beat his own record at the eighth.

From the happy ending of Mr. A.'s sad story we learn how very important it is for the psychosomatic patient to look back to the beginning of his trouble and to do this fearlessly and frankly. He must try to reconstruct the whole vivid picture. This is not always as clear as in the case of Mr. A., but with a little perseverance and the unshakable conviction that something *must* have happened, it can nearly always be dug out.

Now in Mr. A.'s case the purge started the first diarrhoea. That is simple and reasonable. But how was it possible that on all subsequent occasions he got the same diarrhoea without having taken anything? How could an unhappy memory of which he was not even conscious have this dramatic effect? Let us investigate.

We have already been reminded (in Chapter V) that when man is very frightened the body tries to empty the bowel so as to enable him to run faster. Anyone familiar with horses knows that this animal which, like our body, depends on flight for its safety, does the same thing.

The mechanism by which this is achieved is very simple. It is merely an outpouring of fluid into the rectum which liquefies the contents and then a cramplike contraction of the lower gut which expels them involuntarily. That is an age-old trick for which modern man has little use, but which served his unarmed ancestors very well. It still bothers us occasionally because the body has not yet caught up with the new brain-made conditions of civilized life. It is not nearly as absurd as it appears at first sight.

A very similar bodily reaction to emotion is weeping. Normally the tear glands, situated below the eyebrows, produce a steady flow of tears, just sufficient to keep the eyeball moist and clean and to be drained away through the nose without causing a drip. Just as the bowel produces a steady flow of mucous sufficient to moisten and lubricate their contents.

Now under a strong emotion such as sadness, fear, pain, or even, with some people, joy and relief, the tear glands start an altogether excessive secretion which overflows from the eyelids in the form of tears and drips from the nose in spite of sobbing sniffs to hold it back.

To us this seems an altogether ridiculous bodily reaction to emotion, serving no conceivable biological purpose; unlike screaming which at least attracts attention. But there must be some very

sound reason why in our evolution this trick of shedding tears became so well developed. It is interesting that a sudden shock or stark terror does not at first make us weep. We weep when we sit still and face a hopeless situation to which we are preparing fatalistically to resign ourselves.

We do not know the exact origin of emotional tears, but we do know that the sense of sight is to us the most important of all senses. It is the sense we live by just as in the dog's world it is the sense of smell which dominates.

Moreover, we may recall that primitive man's most dreadful enemy was the forest fire. In a fire, an eye unable to shed tears in abundance, would be destroyed beyond repair. Every survivor would be blind. Perhaps this may have played a part in the natural selection of better and better tear glands.

However that may have been, like the diarrhoea of fear, weeping is a survival of man's earliest days when it was a vitally important function.

Thus we see that in tears and nervous diarrhoea we have two very similar accomplishments. The tear glands in our eye sockets and the glands in the wall of our lower intestinal tube can both react with abnormally increased secretion to an emotional stimulus coming from the brain. It would not be wrong to say—though it sounds strange—that in nervous diarrhoea the bowel is weeping.

Looking at our problem from this angle immediately suggests one way of tackling emotional diarrhoea.

We can do the same as the intelligent mother when her child has fallen down and comes running to her crying for all it is worth; not so much because

it is hurt but because it is frightened. The mother says, "Now show me where it hurts." The child says, "Here." "Well that's nothing," says the mother, "It isn't even bleeding." The child continues to cry piteously, so the mother says, "Shame, big boys like you don't cry," and diverts his attention with a toy or a sweet. The tears dry up miraculously. In a matter of seconds the fright and pain are forgotten and the child is playing merrily.

Translating this into terms of emotional diarrhoea, the first thing is to make sure that there is no serious injury—in this case, organic disease. Once that is settled the patient must have his anxious attention to the bowel diverted. In the adult we do this by shifting the emphasis from the bowel to the brain.

Nothing surprises the patient more than when he goes to his doctor, confidently expecting a nice bismuth mixture, and finds that the doctor after a careful examination is out to connect his diarrhoea with trouble in the office, his home or his nerves in general. This gives the patient an entirely new slant on his complaint and, provided the doctor can prove that the patient is really worried and can further convince him that worry can cause diarrhoea, the patient, sceptical at first, soon begins to string along with the doctor's reasoning.

Most men are ashamed of weeping because they feel that they are making a rather disgraceful exhibition of their emotions. They do not feel the same way about their diarrhoea. Making them do so helps them to get out of the habit.

In hot countries where dysentery is prevalent it is common to encounter patients who follow an

acute attack of dysentery long after the infection has been controlled, with continued diarrhoea which keeps them in a state of alarm because it is mis-called *chronic dysentery*. That many of these cases are nothing of the sort is apparent from the large number that can be completely cured with a few psychotherapeutic sittings. It is the fear of diarrhoea that produces the diarrhoea of fear. Presently we shall have to refer to dysentery again when we discuss *mucous colitis*.

In controlling nervous diarrhoea, the most important instruction is to ignore the urge to evacuate more frequently than once a day at the appointed time. When this is first suggested most patients smile wryly. They feel that the instruction is fatuous. Their urge is far too compelling to be ignored. Here a little further explanation is necessary.

All of us have had the experience that just as we were about to repair to the lavatory in response to an urgent call of nature something happened which prevented us from going and completely absorbed our attention. Later we remember the incident and wonder why now we feel no such urge. Though we may have felt we were going to have a loose motion at the time, our next stool turns out to be perfectly formed and normal.

There is a simple explanation for this. We have just learned that our bowel can suddenly pour out fluids which produce diarrhoea. But in the last chapter we saw that the lower bowel is also able to absorb large quantities of fluid. This happens every time we get a mild fright of short duration. As long as the emergency lasts the bowel secretes

water; as soon as the emergency is over, this surplus fluid is reabsorbed. Unless the emergency is very great, we notice nothing of all this. That is normal. But in the victim of nervous diarrhoea the emergency does *not* subside, so no reabsorption takes place.

Many patients dare not leave the house without emptying their bowels for fear of being caught short in awkward circumstances. Bad cases dare not leave the vicinity of their bathroom at all. They become complete invalids. They can think of little else than their bowel.

Let us recapitulate the sequence of events in such a severe case.

After the last liquid motion the lower bowel is completely empty. On account of the patient's low threshold of consciousness (*see Chapter II*), he is consciously aware of the slightest movement of faecal matter coming down into the rectum from higher up. This sensation puts his brain into a state of alarm because he wrongly interprets it as the inescapable prelude to yet another visit to the W.C. The bowel responds to the alarm by starting a profuse secretion. This rapidly increases the tension inside the rectum which in turn further increases the patient's desperate plight. If even at this late moment the autonomous nervous system would get a signal, *danger passed and all is well*, which it would do if the mind switched over to something pleasant, it would put the process into reverse, reabsorb the now unnecessary liquid and no stool would result. But our patient never gives it a chance to do this because he does not know that a premonition of diarrhoea does not inevitably lead to a watery

evacuation. Nor does he realise that it is his own fault that in his case it invariably does do so.

Apart from the discomforts and the handicaps that this condition brings in its train, such patients add to their misery by indulging in the most fantastic speculations as to what is causing their trouble. They swaddle themselves in flannels and avoid baths and draughts. They torture themselves and their household with complicated diets and the queerest feeding habits. They swallow pills of which expensive vitamins are the least harmful. They can, if they are rich, drive every physician in the city to distraction. About the only thing they never do is to consult a psychiatrist.

Once a firm, conscious link is established between the disorderly bowel and the emotionally perturbed brain, as soon as the sufferer clearly realises that the urge to evacuate is not physiologically compulsory, quick relief is usually obtained. Here, as in most psychosomatic disorders, insight into the mechanisms at work de-automatizes the wayward sequence of reflexes which are responsible for the complaint.

Chronic colitis for which there is no obvious and imposing organic explanation is a psychosomatic disease. It differs from the diarrhoeas we have just discussed in that it is associated with a profuse production of mucous. It is particularly common as an aftermath of dysentery.

The emotions that produce this type of diarrhoea are not fear and anxiety, as in the watery type. They are disappointment, frustration, resentment, disgust and unhappiness.

Fear being absent in such cases the bodily mechanisms involved are entirely different from

those already described. Except in the very worst cases this diarrhoea is neither as violent nor as uncontrollable as the former type. In fact, such patients often pass stools which might be considered normal in consistency were they not evacuated with a copious secretion of mucous.

Another important feature of this type of diarrhoea is that it is invariably painful, which the watery type never is. The pain ranges from a mere tenderness to pressure over the colon to severe gripes, almost amounting to colics.

Finally there is this difference that when a patient suffering from the watery type has finished evacuating—which he does in a matter of seconds—he feels temporarily relieved while the sufferer from mucous colitis feels worse after evacuation because he does not experience a feeling of relief and satisfaction. He suffers from what is known as *tenesmus*, a continued and often growing urge to evacuate after the rectum has been emptied. A most distressing sensation.

While nervous watery diarrhoea is, as we have seen, primarily a disturbance of intestinal secretion, colitis is a disturbance of intestinal mechanics in which the muscular system of the bowel is involved.

The muscles of the gut consist of fibres which run lengthwise and others which are circular and run round the tube. Both these sets of muscles are controlled by the autonomous nervous system. In health their delicate interplay results in a motion which we call peristalsis and which can best be described as a milking action. Its function is to keep the intestinal contents on the move. It runs in waves of contraction and relaxation throughout

the entire canal in the direction from the mouth to the anus.

Now in mucous colitis the contractions become abnormally violent. The harmony of their smooth interplay with dilating mechanisms is upset.

It is as if a powerful dairyman were to use all the strength of his grip on the cow's teat, squeezing it much harder than necessary and instead of working in a slow steady rhythm, leaving ample time for the teat to refill with milk before the next stroke, work at a furious pace. Most of the time he would be working on an empty teat and in a short while seriously damage it.

A very similar mechanism explains mucous—or as it is often and correctly called—spastic colitis. There is, however, one important difference. Our hardy gut is far better equipped than a cow's teat to stand such rough handling.

The inner lining of our large intestine is a complicated and delicate structure and needs a liberal supply of blood to feed it and keep it in working order. Its surface is always covered with a film of slippery mucous which effectively protects it from mechanical injury which hard particles in the bowel might otherwise cause. We see therefore that among its many other activities the production of mucous is yet another normal and important function of the bowel. In all living things mucous fulfils the requirements of lubrication just as oil and grease protect our machinery from wear and tear. It is an ideal lubricant.

Now it is easy to understand that when the over-excited ring-muscles grip the bowel like a vice, they compress the small blood vessels that feed the lining

tissue. This lowers the membrane's resistance. Moreover, when the gut is empty as a result of excessive evacuation, it grinds upon itself, so to speak, without having the normal bulk of stool to play upon. Just as our foolish dairyman will create far greater havoc by trying his tricks on an empty udder than if he went to work on a full one.

When a machine works faster it requires more lubrication, so in our body stronger constrictions call for more mucous. The autonomous nervous impulse which produces a contraction of the intestinal ring-muscles also produces an increase in the secretion of mucous. This is as it should be. The mucous protects the inner lining and, when sufficiently copious, gives the angry gut a smooth and harmless filling upon which to vent its indignation.

Thus we see that far from being an alarming abnormality, a disease in itself, a confounded nuisance, it is in fact a most useful safeguard. Nothing could be less desirable than trying to stop the production of mucous without getting at the root of the trouble which lies in the brain. In these cases it is the brain that creates conditions to which the autonomous response takes the form of altogether excessive intestinal cramps.

Here too a vicious circle is involved. The more mucous appears, the more annoyed the patient gets because he does not understand. The more annoyed he gets the more the bowel contracts which in turn produces yet more mucous. We must break this vicious circle and drag the patient out of its spin.

The first step is to convince the sufferer of the connection between his frustration over having been refused a rise in pay, having been swindled or

posted to a place he does not like or whatever his particular grouse may be, and his colitis. The best way to do this is to take the trouble to explain matters. In stubborn cases a little autonomous nervous dope as explained in Chapter II, to calm the exasperation caused by the brain, may be helpful.

Finally, the patient must co-operate by making an earnest endeavour to keep his gut full instead of empty. He must learn to do just what we taught the *constipated* patient to do in the last chapter. That is, eat more and have less motions by ignoring his false urge to evacuate. That this direction is the same in *constipation* and in mucous colitis, which is usually classed as a kind of diarrhoea, should not confuse the reader for in both cases it is the abnormally empty gut which gives rise to much of the trouble.

Why then, the attentive reader may ask, is constipation not regularly associated with excessive secretion of mucous, and why does this not happen in the diarrhoea of fear? That is a very sensible question. The answer is that in *constipation* the emptiness is voluntarily achieved by a misdirected effort of will not by an autonomous mechanism. The ring-muscles involved are those round the anus and in the rectum, while in the case of the watery diarrhoea of fear an excessive secretion and lack of absorption cause the trouble, an autonomous mechanism entirely different from the one producing cramps and mucous and involving the ring-muscles of the whole large gut.

A further question likely to crop up at this point is: how can we expect a cure as long as the grouse,

worrying the brain is not removed? That sounds like logical reasoning and yet it is only the brain's way of thinking. The body has a different logic of its own; the logic of primitive reactions to the brain's complicated and abstruse emotions. Of the brain's abstract reasoning the body takes little notice. It is with the emotions that it tries to cope as best it can. Therefore, the moment we can lift an emotion into the realm of pure reasoning; as soon as we can persuade the brain to scrutinize the emotion, look it straight in the face and deal with it in a rational manner, the body loses all interest. As far as it is concerned the emotional emergency is over and it very soon settles down to its usual comfortable equilibrium. That is the method by which psychoanalysis achieves such incredible cures and why in simpler cases a clear exposition of the situation yields immediate results.

Finally there is a third type of nervous diarrhoea in which the irregularity concerns the stomach and not the bowel at all.

There are certain nervous conditions—we shall discuss them in detail in Chapter X—in which the stomach ceases to produce its normal digestive juice. When that happens the first important phase of digestion cannot proceed as it should. Food which has only partially completed stomachic digestion is moved on into the next part of the tract before it is ready to do so. The result is that the following parts of the digestive tube are unable to handle it in the usual way and so very sensibly decide to get rid of this useless material as quickly as possible. They hurry it along and thereby produce a mild diarrhoea such as may result after the ingestion of unac-

customed or spoiled food. In these cases the bowel is behaving quite normally. Such diarrhoea—we call it *gastrogenic*—can only be cured by putting the nervous disturbance in the stomach in order. Chapter X will explain how this is done.

CHAPTER IX

Vomiting With a Vengeance

VOMITING is a very useful trick. It enables the stomach to get rid of anything it cannot handle or which is harmful, before it gets further into the body. It is an important safety device to which many of us owe our lives.

In the last chapter we learned something about peristalsis, the waves of contraction which propel the intestinal contents on their way. The peristalsis of the stomach, which is extraordinarily powerful, not only propels the food, it also kneads it, mixing it thoroughly with the digestive juices, breaking up the softer particles which we swallow and generally making it into the more or less homogeneous paste with which the small intestine finds it easiest to cope.

We may regard vomiting as the result of this peristalsis going into reverse, pushing the contents upwards instead of down. This reversal is often accompanied by sudden pressure from muscles outside the stomach itself, such as the diaphragm and the abdominal wall which put the force behind the ejection. The whole act is a dramatic autonomous reflex which is, however, governed by a little centre in the brain. This independent little centre is only vaguely and loosely connected with the mind but that such connections do exist is shown by the following example.

We explain sea sickness and air sickness by assuming that an excessive stimulation of the centre of

equilibrium—which we know to be situated close to the centre of vomiting in the brain—sparks across and sets off the centre of nausea. It is a kind of short-circuiting. The mind has nothing to do with this comparatively simple reflex. Yet on the other hand it is common experience that when one passenger vomits, those close to him are particularly prone to follow suit. In such cases it is the mind activated through the impressions conveyed to it by the senses which starts the reflex. It is well known that some people experience a sensation of nausea when going aboard a ship securely tied up alongside the quay, merely by associating the smell of tar and of the engine room with past unhappy experiences. Again it is the mind which is responsible.

The following will illustrate this even more clearly.

It is well known that I have an excellent cook and that in accepting my invitation to dinner you can be sure of a delicious meal. Well, you do have an uncommonly delicious meal which you have thoroughly enjoyed and for which you have not stinted your praise. We have left the table and have settled ourselves comfortably in a pair of easy chairs with an aromatic cup of coffee and a cigarette. It is then that I gravely proceed to make a confession. I explain that just to prove to you how excellent my cook really is, I had ordered him to prepare the main dish out of the remains of a dead cat which we had found in the gutter. "You may have noticed," I add with a smile, "that I did not partake of that particular dish, the stew of which you took a second helping!"

What happens to you? You turn pale and after a few moments you jump out of your chair and

make a dash for the lavatory. Callous brute that I am, I chuckle while I listen to your horrible retchings.

After a while you return, green in the face and furious, but before you can start giving me a piece of your mind, I explain that the whole thing was just a joke. The stew was made of the finest lamb which indeed it was.

Your misery was not caused by bad food. It was due to a disgusting belief. It is just a situation of this kind which is responsible for the beginning of nervous vomiting.

Such patients who have usually been subjected to innumerable examinations, tests, diets and treatments before they reach the psychiatrist, need nothing as appalling as the idea of having eaten a dead cat to make them vomit. They vomit at the slightest provocation because months of practice have run in the abdominal mechanism so beautifully that it responds to a mental hair-trigger. Moreover, by the connections between the mind and the centre of vomiting in their brain.

Nervous vomiting differs in many features from the vomiting caused by bodily distress. It is by these differences that it is easily recognised.

There is a marked discrepancy between the severity of the complaint—the patient and particularly his relations often claim that for many weeks every morsel of food has been brought up—and the patient's nutritional and general condition which is far better than one would expect under such distressing conditions. Then there is the extraordinary attitude of the patient to his complaint. One would imagine him to be seriously alarmed and perturbed.

Not at all. He suffers with calm resignation. He seems somehow strangely detached.

In dealing with many such cases one often has the feeling that they rather enjoy the family's frantic attempts to get them cured, they willingly submit to every kind of examination and treatment and seem to get a secret satisfaction out of each subsequent failure to make them keep down what they eat. It is as if they were saying: "Do what you like I shall continue to vomit because it suits to me to do so. It has made me an important person. I have never been so well and solicitously treated as now. It has relieved me of all my former drudgery. In short, I don't want to get well again and sink back into the indifference with which you all treated me and my bodily welfare before I got ill."

And indeed once the patient has fully developed the knack, his vomiting causes him practically no suffering. Without a trace of nausea he regurgitates his food with an emotional satisfaction that reminds one of nothing so much as a ruminating cow.

In most cases of nervous vomiting there is a strong subconscious motive. Sometimes this is easy to discover, sometimes it needs the full rigour of psychoanalysis to bring it into the light of conscious contemplation. But we have already seen that it is not always necessary to unearth a *complex* in order to stop a symptom; much as we can stop a headache with a tablet of aspirin without going into the details of what caused the headache. In most of the common psychosomatic disorders all that is necessary is to convince the patient that his physical abnormality is caused by an emotionally troubled brain and nothing else. This insight alone interferes

with the reeling off of the disorderly reflex or automatism and thereby restores normal functioning.

Thus such a patient can be helped by convincing him—and above all his anxious relatives—that this type of vomiting is always nervous and that the hunt for any other diagnosis is a futile waste of time and money. Secondly, by explaining—in private session with the patient—that though effective as a means of eliciting attention, affection and sympathy his disorder also represents a terrible handicap to leading a happy normal life and is thus a very dear price to pay for these amenities of emotional security and warmth; that it is a cumbersome way of banishing a feeling of inferiority. Even patients who are quite unacquainted with psychoanalytical thinking listen to such talk in glum silence and yet always seem to grasp what one is driving at. Though often reluctant to admit it, they appear relieved and happier at the end of such a session.

Finally, they need practical advice. Nervous vomiting is usually strongly *conditioned* (*see Chapter IV*). Treatment, therefore, aims at removing as many conditions as possible. Frequently, patients have themselves observed that when they dine in a restaurant with someone they wish to impress they can eat a hearty meal without vomiting; but as soon as they get home and drink a cup of tea up it comes. The home and its inmates condition the reflex. They often relate this in a way that makes one feel that they are out to get the poor doctor thoroughly baffled. They don't seem to realise that they are letting the cat out of the bag.

Sometimes the family or the patients themselves hold a receptacle in readiness to receive the emo-

tional peace offering. Very soon the mere sight of the receptacle becomes a powerful conditioner which it is essential to keep out of sight and out of reach.

I have often succeeded in making a case of nervous vomiting eat a hearty meal and retain it by the simple expedient of eliciting a promise not to leave the chair and then placing them in the middle of the best carpet in the house and there letting them eat their meal without anybody being allowed to set foot on the carpet with a receptacle. The patient should wear his or her best clothes and be amused with lively conversation. Usually the combined respect for promise, clothes and carpet, my presence and the unusual set-up are sufficient to suppress the reflex. The result of this little trick surprises the patient as much as anybody. It only has one snag and that is that the simplicity of it all sometimes offends a disgruntled aunt who for weeks has been holding forth on the seriousness of the case and the stupidity of the doctors who refuse to recognise the obvious signs of pregnancy in a female or an ulcer in the male as the case may be. Her verdict is "Tomfoolery, that's what I call it!" Woe betides the patient that falls for her pronunciamento!

In the early days of the trouble when a rational explanation is being sought, food is usually blamed. In his vomit the patient or some other well-meaning busybody discovers an undigested bit of carrot or beetroot from a meal taken the day before. This discovery is heralded as conclusive proof that the patient cannot *stomach* beetroot or carrot or whatever the offending ingredient may be. It is henceforth rigorously excluded from the diet and the

patient is forced to believe that it was the beetroot that made him vomit, that the exit from his stomach is blocked and that *whatever he eats stays in his stomach for days*. The result is inevitably a cruelly restricted diet which as time goes on gets more and more bizarre even to the extent of excluding milk "because it curdles."

The scrutiny of the vomit by wise women is a constant and perilous feature of nervous vomiting. It must be stopped categorically. Milk always curdles in the stomach, it would be a sign of severe indigestion if it did not. Moreover, our stomach has many folds and nooks in which morsels of food can be retained for several days without this being in any way abnormal, particularly when, as in our case, the regular peristalsis has become muddled.

For the patient who has really made up his mind that this nonsense has got to stop there is a simple, effective and physiological direction to be followed. It is to swallow back anything that regurgitates into his mouth. This most successfully takes the element of drama out of the performance, but more important still the voluntary act of swallowing temporarily forces the stomach to a normally directed peristalsis, that is, towards the small intestine instead of towards the foodpipe.

The success of all these directions depends on the willingness of the patient to co-operate on his being really convinced intellectually and emotionally of the desirability of getting out of the rut he has got himself into.

Here again the technique of harking back can be very helpful. If the emotional set-up at the onset of the complaint can be clarified, the patient has

a solid foundation upon which to build his appreciation of the true sequence of events, which led him to adopt this rather revolting form of protest, so often a subtle form of revenge for a real or an imaginary injustice to his feelings.

Very occasionally one does encounter a case where all these various psychotherapeutic approaches fail; where the patient clings grimly to his symptoms; where it is for him a sheet-anchor in his unhappiness which he dare not let go; where the emotional conflict is buried too far down in the subconscious and cannot be brought to light. There regular psychoanalysis at the hands of an expert is the only solution and though it is protracted and expensive this major emotional operation yields spectacular results in such stubborn cases. It is, however, only a last resort.

CHAPTER X

Have You the Wind Up?

IN this chapter we shall discuss a very common psychosomatic condition which has a wide range of symptoms, often simulating organic illnesses, which are then ineffectually of course, treated as such. The condition with which we are here concerned has been aptly called the Gastro-Cardiac-Symptom complex. We shall henceforth refer to it as the G.C.S.

This high-sounding name merely indicates that it is concerned with the stomach—gaster—and the heart—cardia—and that these two organs can combine to produce a very characteristic nervous complaint in which sometimes the heart symptoms and sometimes the stomach symptoms dominate the picture.

By the time the patient reaches the nerve specialist he has usually seen a heart specialist, he has had an electro-cardiogram taken and has been told that his heart is organically quite normal or that he is suffering from a “nervous heart.” This does not help him in the least because he *does* actually feel discomfort, sometimes amounting to pain in his heart. He experiences palpitations, giddiness, fainting and what he calls shortness of breath; all symptoms which to him clearly indicate that they are caused by his heart, as indeed they are.

The assurance that his heart and blood pressure are normal, places him in the unhappy position of

having to reconcile alarming heart symptoms with the negative verdict of the specialist. The patient is inevitably forced to the conclusion that he is suffering from a very unusual complaint which even the eminent heart-specialist has not been able to discover.

A similar situation arises with regard to his abdominal complaints. He has usually undergone a complete x-ray investigation of the whole intestinal tract; he may have had a fractional analysis of the gastric contents performed; his stool has been repeatedly examined; liver function tests and the radiological study of the gall-bladder, all yield entirely negative results. He may even have had a "chronic appendix" removed without obtaining relief.

In spite of these negative findings he is actually suffering from a marked loss of appetite, an inability to digest his food, heaviness, distention, crampy discomfort in the pit of his stomach, excessive belching, in fact, a number of very real, disturbing and most uncomfortable symptoms.

If he has been told that the investigations are all negative and that organically there is nothing wrong with him, it is almost impossible for him to avoid the conclusion that his medical advisers are politely suggesting that he is imagining a lot of non-existent complaints, a position which is, very understandably, exasperating, infuriating and terribly frightening, because he knows perfectly well that he is not imagining anything.

Thus again he concludes that either the doctors are grossly incompetent or that he is suffering from a disease as yet unknown to science. He has prob-

ably heard that certain fatal diseases are difficult to diagnose in their early stages. The weaker type of patient will continue to have all the tests repeated at regular intervals while the stronger type will seek relief, and sometimes obtain it, from quackery.

The unfortunate thing about the G.C.S. is that both the doctors and the patient are right and that both parties find it impossible to reconcile their opposing attitudes.

In these cases orthodox analytical psychiatry can do little, because the emotional factor lies too near the conscious surface. No amount of analysis will get the patient over the very simple and straightforward, well-reasoned dilemma of having distressing physical complaints in his allegedly normal body.

It may be a very minor annoyance, worry or anxiety, such as a sick child, a new and inexperienced secretary in his office, altercations with his brother, an impending academic examination, a hitch in a love affair or anything as simple as that, which starts the trouble. There is usually not the slightest difficulty in finding out what had happened when the symptoms first appeared; in harking back as we have called it. The patient is most willing to be co-operative and hardly ever shows any tendency to hedge. In this respect he differs fundamentally from the patient suffering from nervous vomiting. The latter, having little discomfort and a big grouse is less co-operative than the patient with a G.C.S. who has a little grouse and a lot of discomfort.

The point is that though some minor emotional upset must have started the trouble, this upset has long since been overcome. It has been fully replaced

by the much more violent alarm at being burdened with an undiagnosable and therefore apparently incurable affliction. In other words, the initiating emotional flutter is no longer directly responsible for the present condition. Its discovery and elucidation gets the patient nowhere.

The G.C.S. is a typical example of a psychosomatic disorder in which a careful and detailed explanation of what actually takes place, that is, a positive rather than a negative approach yields remarkable results without any probing into the patient's subconscious mind. We base our discussion on the assumption that what all the previous specialists have said is perfectly correct. We stop looking for diseases but we unhesitatingly admit that the patient's symptoms are very real indeed; that they are far more distressing than most organic complaints and that though his heart and his stomach may be anatomically faultless they are certainly not behaving in a regular and normal fashion.

The individual variations in the symptoms produced by the G.C.S. are almost unlimited. I do not intend to weary the reader by enumerating them all, but I will give an illustrative case history:

Mr. C., aged 32, had been a junior executive in a large commercial firm. He had done a piece of particularly brilliant work and was rewarded with a sudden promotion to a much more responsible job for which several of his less-gifted seniors had been striving for years. They attributed his success to sheer luck, his pretty wife, his servility, his bootlicking, his good cricket, in fact to anything they could think of other than the real reason. They made no secret of their views and set out, by

endless harrassment, passive resistance and hostility, to bring home to the boss what a blunder he had made by promoting Mr. C.

Mr. C. decided to put up with this petty bickering about which in fact his boss himself had warned him. Yet soon he noticed that for no apparent reason his heart would start palpitating. Gradually he lost his appetite and his sleep was disturbed. He had a peculiar feeling of heaviness in his stomach as if wind was pressing upwards. Often he had difficulty in taking a deep breath which made him gasp. When this most uncomfortable condition was at its worst he felt giddy and faint. On several occasions he had to sit down to save himself from falling. Gradually all these symptoms became so bad that they began to interfere with his work. So he consulted a doctor. He submitted to the most elaborate investigations of which the outcome was entirely reassuring. He was given a bromide—which incidentally annoyed him intensely—and was prescribed a short holiday. He enjoyed his holiday and was comparatively, though by no means entirely, free of trouble.

On his return he was delighted to find that he had been transferred to another department where he would be away from the old and jealous associates, who had been pestering him. He, however, met them occasionally in the corridor and discovered to his dismay that such meetings were sufficient to set his old troubles off again.

Now he became really alarmed and in a very short time he was worse than ever. He felt that sooner or later this would seriously jeopardize his career and so he started on another round of special-

ists who again assured him that there was nothing wrong and that there was no cause for his alarm. But this did not decrease his anxiety, in fact it increased it. Again he took sick leave but this time it did him no good whatsoever.

By the time I saw him he was a pitiable wreck, his poor wife was desperate and his bosses were bemoaning the impending loss of a young man who had held every promise of becoming an exceedingly useful member of the firm. His evil-wishers were already rubbing their hands in triumphant glee.

In the consulting room the patient was in such a state of terror and hopelessness that I had some difficulty in obtaining a detailed history. He kept on interrupting his narrative with deep soughing sighs, he pressed his left lower ribs, asked for a glass of water, excused himself for belching in my presence, and fidgeted most uncomfortably in his chair. The diagnosis of a clear cut case of G. C. S. was easy.

Here follows the gist of the explanation that cured him completely in about an hour:

Please turn to the end of the book and open out the Diagrams VII and VIII.

Fig. VII shows you and your inside before you fell ill. You see from the expression of the face that you were then quite happy, healthy and contented. You had no worries, you could concentrate on your work, you slept well at night, in fact, you were a perfectly healthy normal human being. Now in that mental state the positions of your internal organs were as you see in this picture. As you know the heart lies almost in the middle of the chest and is resting with its base on the diaphragm. The dia-

phragm is a partition which separates the chest from the abdomen. You see that in this picture it is nearly horizontal. The little arrows show that the heart is working quietly and normally pumping an adequate supply of blood to the body and the head through the big vessels. Such a person never feels his heart, he gets no palpitation, because his heart is in its normal position where it can do its work satisfactorily.

Below the diaphragm you see the stomach connected with the mouth through the foodpipe. In the top of the stomach you see a small bubble of air. All normal people have a bubble of air in the stomach and they maintain this bubble by occasionally swallowing air with the saliva as it collects in their mouth. This air-bubble enables the stomach to mix the food better in the course of the normal process of digestion. You further see that this normal stomach contains ample gastric juice consisting mostly of hydrochloric acid. You also see that the powerful ring-muscle at the end of the stomach is open. This means that any excess of acid or any excess of air in the top of the stomach can very easily get out. The digestive juice runs through this open muscle into the duodenum, the name we give to the first part of the small intestine.

If, for some reason or other, too much air is swallowed, this air can either be removed by belching, which means that it is pushed up through the foodpipe or it can escape through the ring-muscle into the small intestine where it is gradually absorbed. In this way a perfect equilibrium of gastric juice and air is maintained.

Such a stomach is always ready to receive food .

which it can easily digest because there is an ample flow of hydrochloric acid. In fact, such a person, as I have drawn in this picture, never has any difficulty. He runs through the whole complicated process without knowing anything about it and without having any unpleasant sensations. This picture, then, represents *you* before you fell ill as also the conditions obtaining in your inside when you are not actually having one of the attacks from which you suffer.

Now look at the second diagram shown in Fig. VIII. It will show you what happens in your inside when you have an attack.

You see, this person is quite obviously ill. The expression on his face is one of worry, fear and anxiety. He is obviously suffering from some considerable discomfort. The little arrows in his brain show that he is very unhappy and thinking furiously. This person has gradually lost his self-confidence; he finds it difficult to concentrate on his work; he does not get sound, peaceful sleep at night; in fact, he is thoroughly miserable.

Now when the human brain is in such a condition this has a very extraordinary effect on the body which I have tried to sketch in Fig. VIII. The first thing that happens is that the stomach stops producing hydrochloric acid. Even in your healthy days you must often have experienced that when you sat down to a meal with a thoroughly good appetite and you suddenly received some bad news or a shock you, from that moment on, could not continue to eat. Your appetite had completely disappeared. This was because any shock or upset first reacts on the body by stopping the secretion of hydrochloric

acid in the stomach. We have already learned that this is a normal, though primitive, reaction to fear. It is that indigestion with which the body forces us to stop eating so that we may be better able to run away, should need arise.

Now when there is a lack of hydrochloric acid in the stomach the ring-muscle at the end of the stomach closes tight so as to keep what little acid remains there in the stomach as long as possible. If the contraction of this ring-muscle is very powerful it may become conscious to you as a pain in the pit of the stomach. The result of this sudden stop in the normal flow of hydrochloric acid is, therefore, that the outlet from the stomach is closed.

In the absence of the normal quantity of acid the stomach becomes uncomfortable and we can imagine that it sends a distress signal to the autonomous centres. These centres respond to this message in a rather surprising way. They make use of a simple reflex, which we call the wall-tension-reflex. When a person eats a large meal it produces an increased tension on the wall of the stomach. It also calls for more acid in order to be digested. There is thus a relationship between the amount of acid produced and the tension on the wall of the stomach. This is a very simple and primitive reflex and it is also the one the autonomous centres choose to make use of, particularly as in the absence of acid you cannot be induced to increase the tension on the wall of the stomach by eating more food. It, therefore, uses another method and that is to make you swallow more air.

Of course, you are not conscious of this process. But what actually happens is that in a desperate

effort to get the acid secretion going again in your stomach the autonomous nerves make you swallow more and more air. They make you pump up your stomach hoping that the increased pressure will produce acid.

This is a perfectly sensible reflex which works beautifully in animals. But unfortunately the human brain has become so powerful that the inhibitory reflex which, out of fear, anxiety, worry or apprehension, reduces the secretion of acid, is infinitely more powerful than the simple wall-tension-reflex. The unhappy result is that you go on pumping air into your stomach without this having the desired effect, namely, the production of more acid.

As the stomach gets more and more distended it pushes the diaphragm high up into the left chest as you see in the picture. In doing so it also pushes the heart out of its usual position as you see when you compare Figs. VII and VIII. Even if the autonomous nerves did not actually make you pump air the same result would follow from the normal swallowing of air with the saliva because such air cannot get out as long as the stomach ring-muscle is closed.

As long as the tip of the heart is beating against that part of the chest-wall against which it always and normally beats, you cannot feel the heart-beat, but if the tip of the heart is pushed right up into the chest it beats against a part of the chest-wall against which it normally does not beat. This immediately becomes conscious to you as *palpitation*.

But it also has other very unpleasant effects. First of all you see that when this distention of the stomach

takes place it compresses the left lung. This gives you a feeling that you cannot get enough air into your lungs and it makes you take deep, sighing breaths. This kind of breathlessness is quite different from the breathlessness caused by a disease of the heart. In such cases the breathlessness is a kind of panting. *You do not pant, you merely have a feeling that you cannot breathe freely.* That is because your left lung is being squeezed by your distended stomach and your heart.

When the heart is pushed out of its normal position this can produce a very unpleasant pain in your chest, and if the process goes still further we can well imagine that a kink is produced in the large blood vessels which prevents an adequate supply of blood to the brain. This accounts for your feeling of giddiness. If the distention goes still further it may even result in fainting, which is merely a kind of safety valve with which the body is provided. If a person in this condition faints, all the muscles are immediately relaxed including the ring-muscle at the end of the stomach. The minute that happens the excess of air rushes through into the small intestine, the stomach becomes deflated, the heart drops back into its normal position and after a minute or two, normal conditions having been restored, the patient comes round and feels reasonably comfortable. Because of this safety valve the condition is not nearly as dangerous as it feels.

Now you will understand that the person drawn in the first picture and the one in the second picture are actually the same person with the same organs. In both cases the stomach and the heart are normal as far as the usual tests will show. One cannot say

that the heart in the second picture is abnormal, nor is there a disease of the stomach. All that has happened is that through some shock, fear or worry, the secretion of the gastric juice has been stopped temporarily and that all the very unpleasant after-effects are, in a way, actually the result of your body trying, rather ineffectually, to put matters right. Again we have an example of the mighty brain clumsily creating havoc with the body's fine and delicate adjustments.

The whole thing is of course yet another vicious circle. As soon as the first symptoms appear you, very understandably, get frightened. From your previous most unpleasant experience you know what you have to expect and you anticipate the whole gamut of symptoms. This anxiety, in turn, further decreases the hydrochloric acid resulting in distension and then the unpleasant symptoms caused by this distention make you worry still more.

The important thing for you to understand clearly is that though your suffering is caused by your stomach and your heart, the whole sequence of events is invariably touched off by the brain. Once you have experienced all these unpleasant sensations you develop a hair-trigger. The slightest incident may set the mechanism in motion. For instance, the recollection of a previous attack may be enough to start off a new one. That is why these attacks very often come on when you are resting after a day's work, when your mind is apparently relaxed and free to think of your dilemma or sometimes even during the night.

Your attacks are less likely to occur when you are fully and deeply absorbed by some particular job of

work. On the other hand a slight hitch in the office or at home which normally would pass off unnoticed, now invariably precipitates your distress.

So you see, that both you and your doctors were perfectly right. Your doctors were right in saying that your stomach and your heart, in fact, all your internal organs are normal. You are also right in attributing the various symptoms to these organs. Naturally, your palpitation comes from your heart. Naturally, too, your digestive disturbances are connected with your stomach, but you must understand that these two things do not exclude each other.

Now the question arises, how are we going to get you out of this vicious circle. Actually this is so easy that you can with your new knowledge almost prescribe for yourself. After your stomach has, as is undoubtedly the case, developed the habit of stopping its normal secretion on the slightest provocation, we can counteract this by putting hydrochloric acid into your stomach artificially, by giving you dilute hydrochloric acid to drink. Probably one of your doctors has already suggested this. Possibly too it may have brought some temporary relief. The effect could not be lasting because not understanding what was happening in your body it did not help to allay the mental anguish and anxiety which was the real root of your trouble.

Obviously, if we maintain an adequate supply of hydrochloric acid in your stomach, the whole process will not be able to get under way. The hydrochloric acid will also help you to regain your appetite and to digest your food more easily. There is nothing actually wrong with your digestion or your appetite except that your secretion of hydrochloric acid is

inadequate as a result of fear. Not because your stomach cannot produce enough, it is merely because your brain will not allow your stomach to produce as much as it should. You now understand that by taking hydrochloric acid you can short-circuit your attacks.

You can safely stop dieting; you can eat anything you like and as much as you like and will be able to digest your food perfectly. Keep a bottle of dilute hydrochloric acid handy and whenever you feel as if an attack might be coming on, put 15 drops of the acid in a glass of water and drink it. This will effectively prevent the attack developing. You may take as much of the hydrochloric acid as you like, you may also take it as frequently as you like; it is not a medicine, it is a normal part of the gastric secretion. Your doctor can explain it all to you and will give you the necessary prescription.

If from now on you are careful to short-circuit every attack, your system will very soon get out of the vicious circle, and you will be as normal and as healthy as you were before. If you have become very jittery a good sedative will help you to get over it quicker and ensure a few restful and refreshing nights.

The main point is that you must understand what is happening. Theoretically you do not really need any medicine at all, once you have fully understood, because if you do not get alarmed about the first sensations they will subside by themselves. I do, however, suggest these two simple remedies because they enable you to overcome your complaint almost immediately and counteract any lingering suspicions about your condition which you may still harbour.

In a straightforward case of the G.C.S. the therapeutic result is almost invariably dramatic and completely satisfactory. A second session is hardly ever necessary, though it does sometimes happen that after years the patients suffer a mild relapse in which case it is only necessary to recapitulate the explanations to put matters right again. The G.C.S. is, next to habitual constipation, one of the most satisfactory psychosomatic disorders to treat with an explanation of the mechanisms involved. The clarity produced by an intellectually satisfying explanation sweeps away a mass of bogeys and makes rational contemplation of the situation possible. Pure reasoning leaves the body undisturbed because this is a comparatively recent achievement in man's evolution to which the body, having been left far behind, has not yet learned to react. It is the vague elemental fears of the unknown to which it responds in a way that was once wonderfully useful and efficient but which has today lost its meaning and only embarrasses the conduct of our brain-directed life.

CHAPTER XI

The Lump in Your Throat

IN the preceding chapters we have studied the nervous reactions of the rectum, the large bowel and, skipping the long small intestine, discussed the stomach. Now we go a step further upwards and investigate the nervous behaviour of the foodpipe—the oesophagus as we call it.

There is a good reason why we could skip the small intestine. Though it is one of the most vital parts of our digestive tract, it enjoys a blissful immunity from interference from the mind. The entrance and the exit to our digestive tunnel are subject to the brain's control, eating, drinking and evacuating require voluntary action. The further down from the mouth or the higher up from the rectum we go the more the participation of the brain in intestinal function wanes. Therefore, in the middle portion, the small intestine, it is absent. That is why nervous trouble with the small intestine is unheard of. In obscurity the small intestine performs its onerous duties with unfelt, quiet efficiency and apart from rare mechanical emergencies, a few serious infections and some forms of malnutrition it never gives us any trouble. As long as it remains anatomically normal nothing will disturb its function. It does not concern us here.

The function of the oesophagus is very simple. It merely transports the food from the mouth to the stomach. It does this by the usual bodily

mechanism of waves of contraction moving downward; the milking action with which we are already familiar. As the oesophagus performs only this one function, it is subject to only one nervous symptom, an irregularity of this function.

In the act of swallowing the mouth forms a well-masticated ball of food—we call it a bolus. It lubricates this bolus with plenty of saliva and then, pushing it through the throat, starts it on its downward journey. The upper end of the oesophagus opens to receive the bolus and then lets its ring-muscles—which are of course under autonomous control—contract sharply above it. This contraction moves downwards, pushing the bolus before it until it unloads in the stomach, after which the contraction vanishes, only to be followed by the next wave.

This contraction is powerful and lets nothing escape. That is why we can even swallow air as we saw in the last chapter.

It is this contraction running down the oesophagus which informs our brain that food is moving in the right direction, information which the brain registers with pleasure and satisfaction. This mechanism and its registration are so well run-in that were a contraction to run down the oesophagus without a bolus being driven forward the brain would none the less register this as food being swallowed. This is how the trouble starts.

Whenever such an unmotivated empty contraction occurs the poor brain becomes hopelessly bewildered. It is in a quandary. Though it knows perfectly well that no food has been swallowed it yet registers a bolus passing down the oesophagus. The brain

being an adept at reasoning solves the dilemma by jumping to the conclusion that there must be a lump.

Such wild contractions do not behave normally. Sometimes they remain stationary, sometimes they travel up and down instead of in one direction only. In the first case this produces a feeling of obstruction and in the second case a most disconcerting feeling of a ball or lump moving up and down inside the chest.

This mysterious sensation is terribly real and vivid. To tell such a patient that there is nothing moving in his chest and that he is imagining things just makes him wonder how doctors can be so incompetent and have such infernal cheek.

As so often in psychosomatic disorders the doctor and the patient are both right. Of course, there is no ball moving up and down. In that sense the doctor is right; but something, namely the contraction, is moving. In that sense the patient is right.

Where the contraction is stationary, be it high up near the throat or further down in the middle of the chest, the patient's complaint is that he cannot swallow.

Though this is not realised by the patient, his inability to swallow is not mechanical; it is an inability to get the normal reflexes which control the act to work, simply because they are waiting for a green light from the oesophagus signalling: all clear for the next consignment. Actually such patients can swallow very well if they try hard enough and if they do they find that the act of swallowing supersedes the erratic contraction and effaces it, so that

the patient feels better until the oesophagus begins its tricks again.

The fact that forced swallowing eliminates the abnormal contraction has another aspect which often leads to misunderstanding.

As most people know there is such a thing as a mechanical stricture of the oesophagus. This may be caused by pressure from other organs or parts outside the oesophagus or by scars, growths or inflammations in the pipe itself. Thus when a patient first consults a doctor complaining of inability to swallow, a long string of possible explanations—some of them very serious indeed—immediately present themselves before the physician's mind. Very rightly, he starts a detailed investigation which unless it is very tactfully put across, usually frightens the patient.

It is easy to distinguish a nervous from an organic obstruction by the fact that the former comes and goes in attacks, that it is relieved by forced swallowing and hence never produces a regurgitation of food, while the latter is permanent, is made worse by trying to swallow and often leads to regurgitation. Yet we cannot blame the doctor for wanting to make sure before he gives his verdict.

It is typical of the nervous *lump* that when the patient, in the course of an x-ray examination, is made to swallow a mouthful of barium, the constriction disappears. To the radiologist who cannot see the oesophagus unless it contains barium everything appears perfectly normal. He and the watching physician heave a sigh of relief and delightedly assure the patient that all is well and that his chest, particularly his oesophagus, is perfectly normal. This news has exactly the opposite effect on the

patient of what is intended. Reasonably enough he enquires: "Then will you please tell me what is the matter with me?" All too often the light-hearted reply is: "Oh! just nerves, that's all. I'll give you a little bromide and then you can go home and forget all about it."

When the doctor tries to convince the patient that there is no obstruction what he means is that there is no anatomical abnormality causing an obstruction. Again, in this sense he is right but the patient does not care what sort of obstruction there is, he merely insists that there *is* an obstruction and in this he too is perfectly correct.

When the oesophageal ring-muscles start acting out of turn this is an expression of general nervous tension. In some persons this expresses itself in colitis, in others by a lump in the throat. There are always deep-seated subconscious emotional reasons for the choice of organs through which such nervousness manifests itself. They can be unravelled by the methods of psychoanalysis. For our purposes they are best left severely alone.

Most of these cases clear up as soon as they have fully understood the mechanism at work and realise that their lump is a clever loophole by which the brain escapes from the insoluble contradiction contained in the message that the oesophagus is swallowing food that never went into the mouth.

This is by no means an isolated instance of the brain's ingenuity in this respect.

We have already met the non-existing lump which the *constipated* person feels in his rectum.

I often use the following little parlour trick to illustrate this type of reasoning:—

Cross your index and your middle finger of one hand. Shut your eyes and roll a small pebble the size of a large pea between the tips of both fingers. You will distinctly feel two pebbles, yet when you look there is only one.

The explanation is, of course, that your brain registers the feel of the pebble from the outside of your index finger as well as from the opposite side of your middle finger. In a normal position of the fingers this would be impossible, so it instantly assumes the only feasible explanation that there must be two pebbles. It does this without apparent difficulty and thereby neatly avoids the cumbersome process of taking the voluntary crossing of your fingers into consideration.

Occasionally one comes across a stubborn case of this complaint in persons whose intellect is not sufficiently bright to grasp the purport of the explanation. In such cases our old friend the autonomous dope proves invaluable. Some patients cannot get over the fear that they are suffering from cancer of the throat. In such cases it is wrong to pooh-pooh the idea. The modern patient has heard of too many cases in which the early symptoms of cancer have been overlooked until it was too late. When the complaint does not yield to simple explanation the doctor resorts to the impressive and not altogether pleasant procedure of oesophagescopy which consists of putting a sort of telescope right down the length of the oesophagus. If that is done by a specialist who has had nothing to do with the case and is therefore presumed to be unbiased, his assurance that he sees no sign of cancer and that if need should arise the investigation can be repeated as ,

often as desired, usually frees the patient from his obsession.

The lump in the throat, *Globus Hystericus* as we doctors rather bluntly call it among ourselves, is a distressing psychosomatic disorder which calls for careful handling from the beginning. In its management bull-hearted joviality is quite out of place and only complicates matters for patient and psychiatrist alike.

CHAPTER XII

Oh ! My Poor Back

WITH the last chapter we concluded the discussion of intestinal engine-trouble caused by our lack of understanding of the mechanical principles involved and our amateurish tinkering with them.

The intestinal motor consists of smooth muscles which are, as we have seen, directly under the control of the autonomous nervous system and do not therefore respond to a voluntary order with a brisk contraction.

We now turn our attention to an entirely different kind of muscle which we call a striped or skeletal muscle. These are the big muscles, such as the biceps on the upper arm, with which we are all familiar.

These muscles too are subject to psychosomatic disturbances, but in their case the mechanism involved is entirely different. This we may reasonably expect from their structure, function and innervation which bear no similarity to the smooth muscles with which we have hitherto been concerned.

Skeletal muscles are more directly subordinated to our reasoning power though they do sometimes yield to emotional pressure as when they tremble with fear or involuntarily tighten in shock. Thus they are much less prone to derangements of mental origin.

However, when they do get so deranged the patient is much harder to convince of the true nature of his trouble than in the case of the smooth muscles, the existence of which he has hardly ever

thought about. It is his familiarity with the skeletal muscles and his lifelong experience that they promptly obey his orders, that renders him particularly sceptical of any suggestion that a group of these muscles is in revolt, dares to defy his authority, has made itself independent of his will and is indulging in disorderly behaviour. Yet unless we succeed in convincing him that this is indeed the true state of affairs we cannot entertain much hope of bringing the rowdy member back into the disciplined fold.

We are not going to concern ourselves here with such muscular crises as involve the whole body, the convulsions of a major hysterical attack; the temporary paralysis observed in a nervous faint, caused by the G.C.S. (*see Chapter X*) or the sudden muscular reaction to shock and fright. We are not interested in the involuntary and unco-ordinated movement sometimes observed in organic muscular or nerve diseases nor in paralysis caused by a destruction of nervous tissue.

We have already seen in Part I, Chapter IV, that a sequence of muscular events which has become automatic by training can be jumbled by attention to each phase resulting in complete disorganisation. Stammering is an example, probably also writer's cramp. Here, as in so many psychosomatic disorders, the very effort to overcome the handicap only results in increasing it. Other muscular abnormalities of nervous origin are the tick and hysterical speechlessness. In fact, the number of such ailments is legion. Their enumeration again reveals the interesting fact with which we have already become acquainted, the relation of psychosomatic disorders to man's evolution.

In the development of man from his animal ancestors certain muscles gained an entirely new importance, some older muscles vanished because they became obsolete, while new ones evolved. It is interesting to note that it is the most recently developed muscles which give the most psychosomatic troubles. From an evolutionary point of view the younger muscles are not as well trained as the older ones. It is as if these youngsters were boisterous and full of their own importance. They are particularly liable to go on strike—that is, refuse to function—on provocations which the older and more sedate muscles simply ignore.

They have grown up together with the brain. They have, therefore, less respect for its authority. They may either disobey its orders and do nothing, a condition which we call paralysis, or start functioning without orders.

In both cases the brain furiously resents their attitude. It bawls at them, it threatens them and screamingly demands obedience. It refuses to listen to their grievances. This does not in the least impress these young muscles which seem fully aware of their indispensability. Smugly they hold their own. Their reply to the brain is: "You climb down first." Thus the conflict goes on until the brain can be made to control its anger, blow away a lot of bubbling emotional foam and sit down to reasonable arbitration.

In that compact community—our body—the brain is unbeatable when it comes to reasoning. It can, and I am afraid to say it does, easily outwit the most imposing muscle. It is only when it indulges

in a grand display of passion that it is vulnerable and easily bullied by its subordinates.

We cannot possibly go into all the body's labour troubles here but must select a rather common difficulty of this sort by way of illustration.

One of the most astounding muscular achievements of man is his ability to maintain an upright posture. This called for an extreme development of his back muscles. Compared with four-legged animals of our size, our back muscles, particularly in the mobile lumbar region, are as enormous as are the breast muscles of a bird compared with the muscles of our chest.

The muscular support of our spine which carries the head, the arms and all they lift is not a single muscular unit. It is a long battery of small units which can work independently or in unison.

The innervation of this group is complicated as may well be expected when we consider the delicate adjustments needed to maintain our balance. Here, then, we have the makings of a muscle particularly liable to get out of hand. It is young, powerful and important. It is securely situated out of the eye's reach and the hand's grasp. Its function is highly automatized. It is not a muscle accustomed to the glare of conscious prominence.

Having said that much let us take a look at the patient suffering from backache. As usual he is mystified and preoccupied. By a slow and expensive process of elimination he has at last been convinced that it is not his kidneys nor tuberculosis of the spine. He has been assured, though not quite so convincingly, that his complaint is not a repercussion of the sexual sins of his youth. His apprehension

has been baited by the possibility of a *slipped disc*, an impending osteoarthritis—the x-ray having shown a little *lipping* of the spinal bones or the, until recently so fashionable, *myositis*, all of which are ponderous diagnostic speculations which do not relieve his suffering. Female patients often have a long history of gynaecological treatment in which the more drastic measures seemed to have brought temporary relief because, as we shall see, they monopolized the attention and thereby drove the back-ache out of its dominant position.

When at long last this complaint is approached from the psychosomatic angle, that is, if the patient ever has any such luck, he has usually become resigned to a life of suffering and is only consulting yet another doctor because he has yielded to the insistent urging of a friend. The patient wearily relates his story clearly indicating that he considers this a waste of time and stressing his conviction that nothing more can be done, he hints that he is fed up with doctors generally.

Altogether the behaviour of a person with a psychosomatic backache is characteristically peculiar. It is difficult to describe, but easy for the experienced physician to recognise. For instance, when the patient is abruptly asked to sit down while he is talking he can usually do so without difficulty. But when asked to do so under scrutiny during the examination he experiences considerable difficulty. Now it is entirely wrong to draw from this observation the conclusion that the patient is shamming or consciously aggravating. He is doing nothing of the sort. The difficulty is real. Many patients frankly admit that at times they can do things which may

be impossible or very painful a moment later and that this bewilders them all the more. The intensity of pain in the back varies all the time, a thing which an organically caused pain never does; in the latter case, there are fixed limits to what the patient can do.

Before doing any explaining we must make sure that the patient is convinced that his trouble is in the muscles of his back and not in his spine. As long as he entertains lingering doubts about this we will not get results. If not already available, x-ray photos of the spine must be taken. Once that has been settled we can proceed.

Suppose a man keeps his fist tightly clenched for several hours the effort of will required to do this will gradually decrease after the first initial tiredness has passed off. He will also experience considerable difficulty in unclenching his hand again after the experiment. In fact, he will be more comfortable getting it back in the clenched position. We say the hand has become stiff. It needs limbering or loosening up before it can again work normally.

Now, in the case of our hand the brain will willingly and methodically direct the process of rehabilitation because it realises how important the free use of the hand is. If after a fracture the hand has been immobilized in plaster it very soon regains its mobility because the will is most usefully helpful and co-operative. The enterprise is undertaken with a clear and definite purpose which briskly overrules any pain which may be caused by the procedure, while the eye can follow with pride and satisfaction every inch of progress.

In the back things are entirely different. Except in the case of athletes, dancers, and persons anatomically well-schooled—who incidentally hardly ever suffer from psychosomatic backache—the average citizen is almost unaware of the massive muscles in his back and does not know how to handle them. When they hurt him he never considers the possibility of their having become stiff from overstrain, indeed he does not realise that he has strained them.

Like most psychosomatic disorders backache has a reasonable and logical beginning before the vicious circle that keeps it going is established. Perhaps it was an acute attack of lumbago or a fall or a sudden strain which tore a few muscle fibres or a blow which caused a bruise. Something must originally have forced the brain's attention on the back and induced it to order a clenching of these muscles to prevent movements which proved painful. Many patients have forgotten the initiating incident and will stoutly deny its existence. We need not quarrel with them though we know that something must have happened.

Soon the emergency passes off. The brain orders relaxation but finds to its dismay that, though the acute symptoms have subsided, the back is still painful. Now instead of saying to itself as it would do in the case of the much more familiar hand: "Oh well, we'll soon get over that, this is where a spot of exercise is needed," it goes into a panic and clenches the muscles, begging to be limbered up, still tighter. Thus it is that the vicious circle leading to such endless suffering is established.

Clenching is painful but so is relaxation. The

brain cannot understand the reason for this so it plays safe by keeping the back rigid. It is not improbable that this continual involuntary strain is responsible for some of the bony changes which then, much later, become radiologically visible in the spine.

That too is why bone-setters and others of their ilk score such spectacular triumphs in these cases, though they do not realise the true reasons for their success.

With a lot of persuasive patter they pander to the patient's mistaken notion that all the trouble is in the spine. They profess to be about to set matters right by adjusting the position of the vertebrae—a Herculean myth if ever there was one. They warn the patient that it is going to hurt, but comfort him with the assurance that this is but a small price to pay for permanent relief, as indeed it is.

The patient, delighted to have found someone who authoritatively tells him what he *has* got instead of telling him what he *has not* got, and having been given an intellectually satisfying, though utterly wrong, explanation, cheerfully decides to do what he should have done in the beginning, namely grin and bear it.

The exponent of manipulative surgery having thus elegantly re-directed the emotional scene now sets to work on a spot of tough limbering up of the muscles of the back with no nonsense about it. The patient groans but when it is over he feels so wonderfully at ease, that he returns home filled with hope and gratitude. Eagerly he awaits the next sitting. In a short while he is cured. He has been neatly tricked into doing the right thing. Just the

thing, in fact, he was frightened to do because he feared it would make him worse. It was all achieved without moving the innocent and sturdily anchored vertebrae even the smallest fraction of an inch beyond the normal limits of their excursion. It was the back-muscle that was given a good stretch and some badly needed working out.

If the chiropractor would—at least *in camera*—admit his clever little dodge, we doctors would gladly welcome him into our fold. But this we cannot do because he insists on deluding himself as much as his patient.

The victim of psychosomatic backache must realise that without a good bit of pain, suffered gladly, his chances of recovery are poor. The longer and the more severely he has restricted the full relaxation of his back-muscles the more pain he will have to bear, just as is the case with a joint that has been in plaster of Paris. It is astounding what a little well directed enthusiasm will achieve when it is not hampered by emotionally flavoured misinterpretations of the true nature of the condition.

Before closing this chapter I must not omit to mention that occasionally an excessive and painful tension in the back-muscles can be produced as a secondary result of some other psychosomatic disorder associated with increased tension of the internal organs. In such cases it is an expression of generally increased tension and not maintained by a vicious circle of its own.

It is a fairly common experience that in cases of severe *constipation*, colitis, and nervous disorders of the sex organs an associated backache disappears after the underlying irregularity has been rectified.

In such cases, however, it is never a very prominent symptom.

Finally, a backache can have a powerful escapist motive. It can, as is the case with nervous vomiting, once it is established, be used as an effective means of evading an emotional conflict which does not bear conscious contemplation. Such as, for instance, the young religious celibate's almost insuperable urge to gratify his sexual instincts. He uses his suffering as a safeguard against temptation. It can also be used—subconsciously of course—as an escape from uncongenial physical labour or as a singularly effective way of nestling into a warm atmosphere of compassion, solicitous attention and delicious pampering. This is all very well as long as the sympathy lasts, but woe betide the patient when patience gives out; then it is too late to dispose of his now useless symptom.

Such cases founded on a really strong emotional motive will rarely be benefitted by the bone-setter's tricks or the psychiatrist's clarification of the mechanics of his complaint. They need an analytical investigation.

CHAPTER XIII

Don't Count Sheep, Sleep!

SO far we have been dealing with bodily ailments in which the nervous origin was not immediately apparent. This is not so with sleeplessness.

A patient suffering from insomnia hardly ever attributes this to an organic disease of the brain. It rarely causes that deep, elemental terror so often associated with other psychosomatic disorders. Its emotional attributes are annoyance, disappointment, and exasperation.

Most frequently insomnia is a secondary symptom associated with other nervous complaints which occupy the foreground. It is then relieved without further measures as soon as the dominating disorder has been dealt with. It is, therefore, necessary, before entering upon the treatment of disturbances of sleep, to search for an obvious cause of anxiety in some other emotional sphere and to begin by clarifying this as best one can.

However, there remain a number of cases in which the insomnia as such furnishes its own emotional background. Where the sleeplessness itself generates the anxiety which keeps it going, where the sufferer is spinning in a vicious circle. In such cases no benefit will accrue from the elimination of extraneous factors.

We exclude from our present discussion sleeplessness caused by physical pain, febrile restlessness, organic disease of the brain, etc., as also the occa-

sional restless night experienced as the result of a consciously realised anxiety concerning a factual event or an anticipated difficulty. In these cases the patient is fully aware of the reason for his sleeplessness. We confine ourselves to the discussion of such cases in which the patient can find no precise explanation for his trouble.

The term insomnia covers a wide variety of complaints, which range from difficulties experienced in falling asleep, to a feeling that sleep, though sufficient in duration, is lacking in depth. Other patients complain that they fall asleep easily, then re-awaken and find it difficult to get off to sleep again. Yet others are plagued by the vividness of their dreams. Finally we encounter patients who worry about the fact that they do not feel fresh and rested in the morning and believe that they have an abnormally long transition from sleep to complete wakefulness which they attribute either to a lack of depth or an insufficient duration of their sleep.

Most patients who complain of severe sleeplessness also suffer from a frequency of nocturnal urination. Almost invariably they reverse cause and effect by assuming that it is the frequency with which they have to get up to pass water which keeps them awake, though in actual fact it is the apprehensive wakefulness which produces the frequency.

The two processes which cause insomnia are mental supervision and the de-automatization of a normal automatism. These two principles have been explained in Part I. The patient who makes a conscious effort to induce sleep, is closely watching every phase of the transition from full wakefulness over a feeling of drowsiness up to the point at which

he should begin to fall asleep. As long as he does this in an apprehensive frame of mind he will not reach that point.

It is characteristic of such cases that while lying in bed, and possibly reading, they come to the conclusion they might now drop off. They then go through a sort of ritual which includes the bookmark, turning off the light, getting their body into what they consider their normal sleeping posture and then willing the induction of sleep for which they now consider themselves appropriately prepared. Within a few seconds they realise that the hopeful signs of drowsiness which they had just experienced had vanished completely and that once again they were wide awake.

They toss and turn, trying harder than ever to drop off. They become more and more disgruntled as they realise the dismal failure of their efforts. Finally, in desperation, they turn the light on again, jump out of bed because they feel an urge to pass water, pace up and down the room and then throw themselves back on an uninviting bed with an emotional mixture of infuriation and dejection.

It is obvious that in such a state of agitation the normal mechanism of sleep induction cannot possibly operate. Moreover, if to the indignation felt on account of being deprived of the soothing sweet-ness of slumber, are added the common notions about the baneful repercussions of a lack of sleep upon health and vitality, such persons can be driven into a frenzy of exasperation which even haunts them during the day in anticipation of yet another such awful night.

In many cases one has the impression that it is

just those procedures which normally *condition* the induction of sleep, such as switching off the light and assuming a certain position in bed, which become transformed under apprehensive attention into *conditions* favourable to a reversal of the normal automatism and thus produce wakefulness instead of sleep. In such cases the normal automatism can only be restored if these conditions are changed or removed.

Though insomnia is a most distressing complaint, there is one comforting thing about it, that apart from the mental distress it causes, it has, strangely enough, very few repercussions upon physical health. We must learn to look upon sleep as nature's safeguard against physical over-exertion. It is not so much the brain as the body which requires a certain amount of sleep. The brain continues to function even in deep sleep. It is the muscular system and the heart which need the rest. You know that as long as we are sleeping we dream. What we call a dreamless sleep is not really dreamless at all; the difference is only that we do not remember what we dreamt. All remembered dreams are only what we dreamt just before waking. Whenever a person is wakened at any period of his sleep he will always remember having dreamt something just before he was roused. Thus we see that even in sleep the brain remains active.

For most of us, living under normal conditions, sleep is a luxury which we prolong far beyond the body's requirements. When the musculature of our body has reached a stage of exhaustion in which sleep becomes imperative we fall asleep whether we want to or not, but after only a few hours the

exhaustion is overcome and the musculature is ready for fresh work. It should however be remembered that many nervous people strain their muscular system far more than they imagine, even when they do no physical work, simply because they keep their muscles unnecessarily taut all day long as a result of continual fear and anxiety. They thus need more sleep than if they spent their day in bodily relaxation. The indolent obese, too, require a lot of muscular energy for even small movements of their excessive bulk.

You may have heard that in cases where the sleeping centre of the brain has been destroyed through injury or disease sleep becomes impossible. Such persons can none the less lead a perfectly healthy life if they learn to give themselves a few hours of complete muscular relaxation every night. If they can do this without any feeling of anxiety, they are able to carry on with a full day's work. The health of their body and their mind does not suffer to any noticeable extent from the fact that the ability to fall asleep has been lost.

Thus a very important thing to remember is that if the body really needs sleep it will always get it. The trouble with us is that we are desperately trying to force our body to take more rest than it actually needs and, though by practice and habit we can learn to fall asleep long before the body makes an irresistible demand, it is equally true that this habit can be lost if we try to force our body into premature repose.

We must understand that every bit of energy, concentration and will-power that we exert in an effort to fall asleep must inevitably have exactly the

opposite effect. Because we have a notion that we are being deprived of an essential amount of sleep which we think we must, by every possible means, make up for, we work our brain up to a frantic pitch just at the moment when it should be completely calm and restful. Under these conditions it is impossible for our body to perform the little trick of falling off to sleep.

If we would realise that for a few days an hour or two of sleep can be perfectly sufficient we can, with this knowledge, reverse the procedure hitherto adopted. Instead of trying to go to sleep, we can make a real effort to stay awake, and calmly await the moment when our body demands sleep. When that happens we will fall off to sleep without the least difficulty.

Why not try it tonight.

Get yourself an interesting book and make up your mind to get through the first 150 pages. You will go to bed telling yourself that as you do not fall asleep as soon as your head touches your pillow you are apparently not physically in need of sleep so there will be no harm done if you stay awake all night. You will, moreover, say to yourself that the quiet hours of the night when you will not be disturbed are just ideal to get through that interesting book you have never found time enough to read. You will in no circumstances decide that you have now done enough reading and might be able to drop off to sleep. You will not turn out the light, nor will you close your eyes in an attempt to go to sleep. On the contrary you will make a desperate effort to stay awake and read yet another page of your book.

Perhaps you have a notion that in order to sleep darkness is essential and therefore, it will be impossible for you to sleep unless the light is switched off. I want you to realise that the light has nothing whatsoever to do with your sleep. When a person is really physically tired he can sleep at any time of the day or night, even in bright sunshine. You yourself must have experienced on many an occasion that you can sleep soundly after a heavy lunch in the afternoon, that is, in broad daylight. I have never yet met a patient who comes to me complaining of afternoon insomnia.

Now just as deep sleep is possible in broad daylight so deep and sound sleep is possible at night with all the lights ablaze, provided you are really tired, not merely weary.

So tonight read until the book drops out of your hand and fall asleep in whatever position you happen to be at the time. As soon as you are off, your body will automatically assume one of its customary sleeping postures.

If during your reading you fall asleep and then re-awaken, you must make an effort of will to pick up your book again and continue to read until you again drop off. In no circumstances may you toss and turn and contemplate with disappointment and apprehension the fact that you are not getting as much sleep as you think you are entitled to. Nor should you keep a check on the time and calculate the minutes or hours which you have slept. This is an extremely bad habit and can very soon lead to awakening at regular intervals.

People who are in the habit of finding out the time of their awakening during the night very soon

discover that, for no apparent reason, they always wake up punctually at the same time and as they make a conscientious check of whether they awake five minutes earlier or later than the day before, the habit becomes so ingrained that an interruption of their sleep soon develops into a permanent feature. Most people normally wake up several times during the night but remember nothing of it the next morning.

The more intensely our brain works, the more urine is produced by the kidney. Urine, apart from serving many other purposes, appears to some extent to be a waste product of mental effort. You also know that an involuntary passing of urine may result from a shock or a fright. Your brain struggling against sleeplessness works much harder during night than it does during the day in your office. You are also intensely worried by the fact that you cannot get off to sleep when you wish to. So you see, there is every reason why you should pass a considerable quantity of urine at frequent intervals, during a sleepless night. Moreover the urge to pass urine depends on the tension in the muscular wall of our bladder. When fully relaxed our bladder is capable of holding several pints of urine, but under normal conditions the tension in the wall prevents an excessive dilation of this organ and produces the urge to void when a certain degree of filling has been reached. Obviously, if the tension in the bladder is increased the urge to void will be much more frequent. It is a well-known fact that anxiety, such as is experienced during sleepless nights, increases the tension in the bladder. You must, therefore, understand that it is not the frequency of passing

urine which prevents you from getting a sound and continuous sleep but rather your apprehensive anxiety about the sleeplessness which increases the urge to pass water.

An additional difficulty is that whenever you feel the urge to pass water you worry why this should be so. Normally a person who has consumed a fair amount of liquids before retiring, may have to get up during the night. The difference is that he will hardly remember the incident the following morning and if he does, he will pass it off as being fully explained, while you regard it as something abnormal, simply because you have not understood the reason for the frequency you experience. Thus it adds to your alarm.

Before consulting a physician many patients have already experimented with a rich assortment of sleeping tablets. They usually make the mistake of starting with too small a dose and then trying to do without the tablet which they believe to be dangerously habit-forming. They will take a tablet one night and the next night try to fall asleep without any artificial aid until in desperation somewhere around midnight they eventually have to take the tablet after all.

Wherever possible it is, of course, desirable to get back into normal sleeping habits without the use of drugs; but in some cases explanations alone are not sufficient. Patients who are obviously impressed by the explanation can usually manage without resort to drugs. But there are some who show by their attitude that they are not at all impressed, that they do not care whether they get what the doctor considers sufficient sleep. All they want is a solid eight

hours of sleep regardless of whether this is necessary or not. In such cases medicinal aid may be required.

There is a vast number of hypnotics on the market. There is a variety of modern ones which have different actions. Some act quickly, some slowly; others have a short and yet others a prolonged action. There are also various combinations of such types available. Only a doctor can select the one most suitable for your case and advise you regarding the correct dose and time to take it. If you start experimenting on your own it will take months before you discover what suits you best. A doctor who knows your case can tell you that at once.

Modern sleeping medicines do not act like the old-fashioned ones. They are not really a dope. They act by stimulating the sleeping centre in the brain; they are almost completely eliminated through the urine the following morning. They are not dangerously habit-forming. A modern sleeping tablet will generally do less harm than a miserable restless night.

Patients suffering from insomnia who have been given a sleeping tablet very often decide to be cleverer than the doctor. After the first good night they try to manage without the medicine, "Because they don't like taking so many drugs," in spite of the doctor's recommendations to keep it up for a while. This is a silly mistake. One good night is not a case of insomnia cured. It needs several nights of re-training to get back into a normal automatism and every setback involves the necessity of starting all over again.

Sometimes a patient complains of having had a restless night in spite of a strong sleeping dose. This

may be due to the fact that he fought desperately against the artificial induction of sleep. He may be determined to convince the doctor that his is a much more serious case than the doctor thinks. He may be disappointed with the simplicity of the explanations offered. Often, however, such a failure of a well chosen hypnotic is due to a deficiency of bromide in the body. It must be tackled from an entirely different angle.

The way the body makes you fall asleep is through a sudden outpouring of bromide into the cerebro-spinal fluid. If we analyse the cerebro-spinal fluid of a person who is wide awake we will find that it contains only traces of bromide. If we repeat the examination just after he has dropped off to sleep we will find that the bromide content of this fluid is considerably increased. In cases in which we find that, inspite of having allayed all apprehensions regarding sleeplessness and having given a stimulant for the sleeping centre in the brain, satisfactory sleep is not obtained we may be sure that the explanation is a lack of bromide. A concentration sufficient to induce sleep cannot be normally built up in the cerebro-spinal fluid. Obviously a sleeping tablet cannot act in such cases. What we have to do is to provide the body with sufficient bromide to enable the mechanism of sleep induction to operate normally.

Though the amount of bromide required to achieve the necessary concentration in the cerebro-spinal fluid is extremely small we may need a considerable quantity in order to replenish the body's depleted store. Until this amount has been consumed no effect will be noticed, but once there is

sufficient bromide in the body a perfectly natural sleep ensues.

The bromides thus act very slowly. There is no point in taking a dose just before you retire, as you do with the ordinary sleeping tablets. The thing to do is to take the bromide during the day so that your body can gradually absorb its requirements. You may have to take it for as many as 12 to 15 days before you get a deep and natural sleep. Once that is achieved stop taking bromides completely. They can be harmful if taken too long.

Some people insist on taking too much sleep out of sheer boredom, particularly the aged, who can find little else to do. This is unfortunate because old people require far less sleep than young and active ones, yet they complain bitterly of insomnia if they sleep five to six instead of the seven to ten hours they would like to sleep. They also frequently take a long rest in the afternoon which they rarely include in the calculation of their hours of sleep. In these cases little more can be done than to allay any anxiety on this account, and to try to find some form of occupation during part of the night.

Just as a case of chronic constipation cannot be cured with laxatives, so a case of insomnia cannot be cured with hypnotics only. The physician who says: "Oh, you can't sleep? We'll soon fix that," and scribbles out a prescription, is behaving ethically in the same manner as a doctor who, called upon to attend a man who has just fallen off a house, presses a few morphia tablets into the patient's hand saying: "Take these when it hurts," and walks away feeling that he has done his duty.

Emotional bruises hurt more than physical ones.

They also have far less tendency to heal spontaneously unless they are given psychological splints in the form of a friendly and comforting explanation. Emotional wounds need cleaning, dressing and soothing as much as surgical ones.

CHAPTER XIV

Fatigue without Rhyme or Reason

WHEN a person is not leading a physically strenuous life and yet, in the absence of clearly abnormal clinical findings, complains of tiredness, listlessness and being run down, he will rarely accept the unqualified diagnosis "nerves." He feels that it must be something physical.

He will enthusiastically place a *septic focus*, such as a couple of teeth or a couple of tonsils on the altar of the Goddess of Cause. He will gladly exchange cash for an extra hundred thousand red blood cells added to each cubic millimeter of his blood. It requires little professional skill to convince him that his case calls for an assortment of vitamins and a *good tonic* or that, if the mercury registers a few millimeters below the statistical average, all his trouble is due to *low blood pressure*.

Here in India where about 60% of the healthy population harbour dysentery germs in their intestines these, generally innocuous, protozoa are particularly liable to be pounced upon with incriminating fury. The lengthy and expensive process of their extermination is a most impressive form of exorcism.

To some physicians with a primarily somatic approach to ill-health, all this is rational and perfectly legitimate; for to them the psyche and its bodily reflections are something nebulous, flimsy and intangible, lacking all the concrete reality of those things they can hear, measure and see with their

stethoscope, their blood pressure apparatus, their microscope, their x-ray and their electro-cardiograph. They are sceptical of *all this psychology-business* only because of a lack of familiarity. They find it difficult to adopt the same attitude of matter-of-fact confidence towards a wounded personality as they assume when confronted with a wounded limb. In their embarrassment they are forced to indulge in what, seen from the psychosomatic angle, can only be described as diagnostic and therapeutic antics reminding one of the capers cut by a hungry cat tempted by a bowl of hot milk. They long to say "nerves!" but they dare not. It might singe their whiskers, and burn up the patient! It would certainly benefit neither. It seems far wiser to look around for shibboleths than to tamper with an elusive psyche.

When a patient, without such specific complaints as would make the experienced physician prick his diagnostic ears, says that he feels generally run down, if the description of his symptoms appears vague, it will be an emotional conflict of which the modern physician thinks first. In such cases it is much more rational to begin by investigating the personality than to expect laboratory tests to cast up a clinically unsuspected diagnosis.

With the provisional diagnosis of an emotional difficulty in mind, the doctor will listen to all the various symptoms which the patient sums up in the expression "being run down." He will be at great pains to discover as much as possible about the beginning of the trouble. Was it a new and unaccustomed responsibility? Had there been some disagreement in the office or the home? Were

there at that time financial or legal worries?

Often patients will not admit anything of this kind. Yet the physician insists that something of an unpleasant nature happened before the trouble in its present form started because he knows that the patient who begins with an emphatic denial almost before the question has been completed, who is anxious to contradict this suggestion even before he has had time to think it over, certainly knows of something but has made up his mind not to speak about it. It may be only an apparently very ordinary thing, a new servant, a new baby, a case of whooping cough, the neighbour's radio or a disturbingly attractive typist.

Though the history of fatigue may produce a very variegated picture, there are nevertheless certain typical complaints which recur with surprising frequency.

By way of illustration let us listen to the story Mr. D. would tell us if he were perfectly frank to an attentive and interested listener.

Mr. D. is the chief accountant of a large shipping company.

This is what happened to him yesterday.

After a, by no means satisfactory, night's rest he wakes up feeling tired and exhausted. Before him looms the ugly spectre of yet another day of exertion and frustration. He sees a terrifying volume of work awaiting him at his desk in the office and ponders dejectedly over the fact that, however much work he will be able to get through, more and more will continue to pile up. In his bath and at his breakfast table he keeps thinking of that difficult letter he has got to write, the conference for which

he must prepare and the alarming approach of zero hour for the submission of his annual statement on which he has not even started. He glances at a few, unpleasantly sensational, headlines in his paper and checks, with considerable apprehension, such market quotations as he may be interested in. Under this mounting tension he cannot enjoy his breakfast. This reminds him of Smith's duodenal ulcer or the chronic appendicitis for which Jones had to undergo a rather uncomfortable operation. He wonders when he will find enough time to make an appointment with his doctor. Meanwhile, he will have to carry on with those digestive tablets some doctor once gave his wife.

On his way to work he remembers the good old days when he felt he could just spit on his hands and tackle any job; when nothing seemed too much; when he relished grappling with a really tough proposition. Now he can only hope that nothing unexpected has happened overnight and that, on his arrival at the office, he will not be faced with yet another difficulty which may well prove to be the last straw on the camel's back. He is filled with the dread that his boss may discover the extent to which his output of work has been lowered. He is already preparing himself with a story of how badly he is in need of leave so that he may be able to counter any pointed remarks which his superiors must surely be contemplating.

In the office he is self-conscious because his stenographer must be wondering why it takes him so long to dictate a letter; why he finds it increasingly difficult to grasp the purport of a correspondence, a thing he used to be able to do at a glance, and

why his dictation has recently become hesitant and muddled. The harder he tries to mend these deficiencies the worse they seem to get. Whereas formerly he could deal with a problem, and having dealt with it, dismiss it from his mind, he is now haunted by a lingering suspicion that owing to his rundown condition he may have slipped up, overlooked something important, or used poor judgment in making a decision.

He is extremely short-tempered with his subordinates. Everything irritates him. A moment's delay in answering his bell appears to him to be an infuriating waste of his precious time. He discovers that his telephone always seems to ring just at the moment when he has, with a supreme effort, marshalled his facts; that every interruption completely upsets his train of thought and makes it necessary for him to start all over again from the beginning. As he feels that the quality of his work has sadly deteriorated, he must at all costs avoid a mistake which might precipitate a crisis in his career and so he suffers from an irrepressible compulsion to check, cross-check and re-check every move he makes, adding enormously to the volume of his work and the time required for its accomplishment.

Lunch-hour. He has got to watch his diet carefully, otherwise he will have indigestion for the rest of the afternoon. He envies Smith and Jones, because they are not nearly so overworked. They find time for half an hour's relaxation, a smoke and a chat. He cannot permit himself to indulge in such luxuries. He must keep his nose to the grindstone because with him even minutes count.

In the course of the afternoon his wife rings up to say that they have been invited to dine with the Bigwigs and that it is, of course, important that they accept. He groans and tells her he cannot stand a dinner and a late night; that he is already completely exhausted; that he is smothered with work; that his one longing is to get home and have the early night he is so much in need of.

His wife stresses the importance of the invitation, but he just cannot face it and tells her to make some excuse. Hardly has he put down the receiver when he thinks that maybe it would be better to go after all, that disappointing the Bigwigs might have all manner of unpleasant repercussions. He is on the point of calling back his wife to say that they had better go after all. But at that moment the office boy calls him to see the boss. Which should he do first? If he rings up his wife the boss will be annoyed at having been kept waiting. He wavers backwards and forwards, and finally, though he knows he is doing the wrong thing, he lets their absence from the party stand. By now he feels that he has already annoyed the boss who probably wants to discuss with him those recent signs of inefficiency of which Mr. D. is only too well aware and which, he thinks, must be evident to all and sundry in the office.

Actually the boss had no such intentions, but Mr. D. regards all the General Manager says merely as a preamble leading up to the point which he anticipates and dreads. He is flustered and ill at ease. He returns to his desk with a feeling that he has made an awful fool of himself and then discovers to his horror that he has no clear conception of what

the boss was talking about and what it was he wanted him to do.

At the end of such a day the patient dreads his home-coming because his wife will have a thing or two to say about the party. The fact that he is now convinced that she is right will only make matters worse. Again he feels a fool because it will be impossible for him to explain the reasoning by which he arrived at his injudicious decision. He knows exactly what is in store for him, all the old unanswerable arguments: "Why don't you tell the boss to get you an assistant if you are so overworked? If you are ill, why don't you see a doctor? What is the use of going to bed early, if you cannot sleep anyhow? Whenever there is an opportunity of meeting some friends or having a little recreation, you are always too tired."

Dinner will be gloomy and glum and in any case it gives him indigestion.

On his way home he thinks how wonderful it would be if only he could throw himself on his bed at this very moment and forget all his misery and worry. He feels so sleepy that he could drop off in an instant and yet he knows that tonight it will be the same as every other night. His career, his office, his boss, his stenographer and his indigestion will rise up around him like mocking phantoms, torture him and deprive him of sweet and well-earned sleep.

From our point of view the most remarkable thing about Mr. D.'s case is that he thinks he is *run down* like the old grandfather's clock in the hall. He thinks that he is losing his memory, his power of concentration, his ability to think intelligently, that

he has lost his previous capacity for work and that physically he is unable to cope with the very moderate muscular exertion called for in a day such as his.

Actually this is the complete reversal of the correct interpretation of his symptoms. He is over-wound or as it is usually called, highly strung. His memory is performing the stupendous feat of remembering and continually reproducing every little incident of the day, the previous week, month or maybe year. He has not lost his memory, he has lost his ability to forget all those minor details the recapitulation of which serves no useful purpose. That in spite of the terrific handicap under which he is working he is still able to produce a certain measure of useful output shows how good his brain is. The wonder is that it can continue to function reasonably well under these most adverse circumstances. His capacity for work, far from being below par, is prodigious. He is now working far harder than he has ever done before. That much of this work does not run into useful and creative channels, is an entirely different matter. It is none the less energy-consuming work. Finally, that his body is tired after a long day of tautness, without a moment's relaxation, is certainly not surprising, nor does it suggest any physical deterioration.

This is the point at which we insert the lever with which we jerk this type of patient back into a normal mental and emotional economy. Here is what the doctor might say to Mr. D.

"Having carefully examined you I find that your body is not in such a bad condition after all. Your heart is strong and healthy, your blood pressure is

within normal limits. You are certainly not so anaemic that this could account for your tiredness and lack of energy. Even your indigestion is certainly a result of nervous tension and worry as I find no evidence of disease in your digestive tract.

"Now, difficult as it must be for you to continue working under the extreme nervous pressure from which you are suffering, it may be even more difficult for you to realise that all your complaints are the result, not the cause of this mental tension. You are under the impression that your capacity for work, your memory, your power of concentration, etc., have sadly deteriorated and that for no apparent reason your physical endurance is much below par. This is an entirely mistaken notion. I will try to show you why.

"The first thing you must understand is that the real explanation of your symptoms is exactly the reverse of the interpretation which you have given them. Far from being below par you are working at a pace well above par. To me it is not in the least surprising that you cannot cope with your job in the office and that after a day's work you have no mind for social recreation.

"You see, the human brain has a capacity for work which, though it is enormous, is not unlimited. This capacity is particularly limited when the work lacks thrill, excitement and pleasurable creativeness, and above all, when it is encumbered with apprehension and anxiety.

"Your brain has for some time now been running to capacity. You are working harder, your memory is better and your output of nervous energy is greater than it has ever been before. The trouble

with you is not that your engine has run down, but that there is some trouble in the gear-box. Your engine is racing at top speed. It is consuming oil and petrol at a very high rate, and yet the car does not run satisfactorily, because you have not got the right gear. You are in the same position as the motorist, who continues to tinker with a perfectly sound engine in an effort to make his car run, because he has not understood how it is possible for the engine to race without the car moving as it should. What I am trying to do now is to show you the lever which will transmit your horse power into motive power, or in other words, to show you that it is merely a gear that is slipping. Again, if we care to spin out this automotive metaphor, you are rather like the fellow who can't understand why his car won't budge though the accelerator is wide open, until somebody comes along and points out that he has forgotten to release the handbrake.

"I want you to realise that all your symptoms are the legitimate results of racing, and not, as you have hitherto assumed, caused by a lack of strength, energy and stamina.

"At this moment every thought you think, every movement you make is weighed with apprehension. This apprehension builds up an enormous resistance against the free flow of thoughts and the relaxed ease of movement. Trying to work as if this resistance did not exist, involves a fantastic effort, far above what is normally required. It is surely not surprising that this effort wears you out.

"To make matters worse you are caught in a vicious circle. First your anxiety produces a small resistance. Then the difficulty of accomplishing a

normal day's work against this resistance, increases your anxiety because you do not understand the mechanism at work. The increased anxiety in turn builds up more resistance and so it goes on until you come to a stage when you are what is popularly called on the *verge of a nervous breakdown*.

" If I have succeeded in making clear to you that neither your brain nor your body have in any way deteriorated, but that you are expecting both to do something which is physiologically impossible, we can go on to the next point which is to find out how all this trouble started.

" You see, mere volume of work never starts this sort of thing; there is always something emotional at the bottom of it. Something disturbing, something which occupies your mind to such an extent that it does not leave enough room for normal and useful activities. Something which is always lurking in the background of your thoughts and there produces a feeling of anxiety and apprehension, possibly even amounting to fear.

" It is also invariably something which you do not care to admit to yourself, something the admission of which would cause you embarrassment. Something you are trying to conceal not only from others, but even from yourself; something mixed up with a feeling of guilt, inferiority or shame.

" Mind you, we are now only talking about what started the trouble. Whatever that may have been, it has probably passed off long ago. Your present difficulties are much more serious because you are now in the middle of a whirlpool which generates its own force.

" I want to make clear to you that it was some

emotional upset that started the thing off, not a physical or mental deterioration, and that your present anguish is nothing strange, mysterious or inexplicable, but rather the perfectly legitimate outcome of an unfortunate misinterpretation of your symptoms. As soon as you realise that you are not run down, that quite on the contrary you are run up, we shall have very little difficulty in putting matters right.

" You must look upon your condition as similar to that of a person who is being pursued by a lunatic with a loaded gun. In such circumstances you would find it just as impossible as you find it now to get through an ordinary day's work, to concentrate, to memorize, to make quick and correct decisions with confidence in your judgment. You would also find an effort to pretend that there is nothing wrong, and to carry on as usual extremely exhausting. Yet because you feel the muzzle in your back, the idea that you might be ill would never strike you, cause and effect would be perfectly evident, and clear to you. As soon as the lunatic is taken into custody you would with a sigh of relief resume your normal unhampered activities.

" Your present trouble is that you are not sure about that lunatic. You have a vague suspicion that he is lurking somewhere, but when you try to reason it out the idea looks like such fantastic nonsense that you would be ashamed to tell Smith and Jones about your suspicions. In fact, you repress them just as you would repress an urge to call in some workmen to move the office safe to make sure that the lunatic is not hiding behind it in an excavation in the wall.

"Now let us be frank and talk this bogey over even if it hurts your pride a bit. After all who knows there may be some truth in your suspicions. On the other hand there may not be. In either case no harm can be done by having a good look round. Even if we find no armed lunatic we may discover a rat's nest which does not belong in a tidy and well run office. But please remember that whatever started you on the downward trend, whether it was a lunatic, a rat's nest or just some silly flippant remark of Jones to which you attached an altogether unintended significance, it was only the beginning. Your further deterioration was the snow-balling of a vicious circle.

"Because you did not understand the position, as I have now explained it, you were tempted to do just the wrong thing; you thought you felt the need of a tonic which would, as you now see, only have made you worse, because you are already suffering from far too much tone. You are driving yourself much too hard. We have got to clear a lot of rubbish out of your memory to make room for something important and useful. We have got to stop your fierce concentration on footling, petty trivialities. We have got to slash into yards of knotted intellectual red tape.

"Obviously we cannot do that with a tonic. What you need is a sedative which will slow down your frantic mental activity. To your surprise you will see that, far from further deteriorating your ability to work, it will have exactly the opposite effect. It will liberate you from just that which is exhausting you now and clear the way for normal useful work which, within a few days, you will again be able to

accomplish with your former ease. It will also relax the physical tension which is the cause of your tired feeling and leave you fresh, cheerful and enterprising in the evenings and over the week-ends, enabling you thoroughly to enjoy your leisure. So when you call upon your doctor surprise him with your insight by asking for a sedative—a good strong one please—instead of a pick-me-up. Only *after* you feel that you are much your old self again, think of taking a nice holiday. If you take leave now you will take your vicious circle with you and in your vacational idleness it will start whizzing till it makes you giddy. Your holiday will be wasted."

We have discussed Mr. D.'s fatigue in detail because his fatigue may have serious economic repercussions for the family, but Mrs. D. too can suffer from the same complaint and this can have serious repercussions upon the happiness of the home. When she suffers from psychosomatic fatigue house-keeping which once she managed with ease, efficiency and pleasure will become an intolerable burden and an exhausting drugery which "finishes" her for the rest of the day.

In her case too there is always a nigger in the woodpile. If we take down the woodpile, uncover the nigger, let him run and then re-stack the logs orderly and neatly, she suddenly recovers her bounce and finds that she can polish off her chores in her stride.

She has been "working herself to death," not because there was so much work but because whatever else she did she was compelled to keep an eye on the weird goings on in that woodpile in her emotional back-yard.

The first thing on awakening is an anxious peep out of the window to make sure that it is still there. Hundreds of times during the day she pauses to see what is happening now and her last thought at night when she gets her first snatch of sleep is wondering what that extraordinary harmless looking woodpile may be up to now. Even during the night she lies awake arguing with herself whether it would not be better and safer to get up, tiptoe to the window and peep into the moonlight to reassure herself that so far all is well.

Her main trouble, of course, is that she dare not speak to Mr. D. about it. He would never understand. His reaction would be "Rot, my girl, that pile is fine; why I stacked it myself. Now don't imagine such nonsense and go to sleep." But she knows what she is talking about. She knows that something queer is afoot, but of course she hasn't got the courage to face the nigger single-handed.

Thus it is the nigger not the housework that is exhausting her. But this she does not realise and so she begins to slip down the spiral at the bottom of which lies chronic invalidity waiting to clutch her in its tight embrace.

Such patients are victims of a cruel misunderstanding, a misunderstanding only. The true extent of their misery too often remains untold and unsung. We hear only of the bodily reflections of this misery. As long as we confine ourselves to these we are playing with moonshine which comes, varies and goes in the much more real darkness of emotional obscurity. Only in the daylight of better knowledge can we dispell the spook. There it melts away so utterly that we find it hard to believe it ever was

a grim reality, like nightmares rampaging through our dreams into the welcome oblivion of the dawn.

CHAPTER XV

The Emotional Stamina of the Female Sex

THE existence of all animal species is maintained by two powerful instincts. The one postpones as long as possible the extinction of the individual in death, by means of fear, rage or ingenuity. The other ensures the propagation of new individuals by the compelling urge of sex.

In the preceding chapters we have been dealing with the first instinct. We have been concerned basically with man's struggle for physical existence, his fear of ill health as a preliminary symptom which he instinctively regards as heralding ultimate dissolution.

Now we turn to disturbances which do not arise from the fear of individual death but from the fear of being unable to satisfy the urge of propagation. Thereby it is merely incidental that in man the gratification of sex has become largely dissociated from its biological purpose, has grown into an independent and unmotivated source of pleasure and has as such developed a new emotional background of its own, independent of the requirements of the species.

That this dissociation is, however, by no means complete is evident from the severe emotional disturbances that may result from surgical sterilization though this does not interfere with the urge and the enjoyment of sex gratification. And that, in women, any amount of sex without motherhood does not in the long run appear to afford complete emotional

satisfaction.

As usual we leave aside all disturbances of sex in which there is an anatomical or glandular abnormality and confine ourselves to the discussion of misinterpretation of the normal physiology of sex.

Here we will find the whole gamut of those basic psychosomatic mechanisms, dealt with in Part I, mischievously at work. The conscientious reader will, I hope, forgive me for pointing out to those inclined to skim that unless Part I of this book has been fully mastered much of what is here to be said will appear dull and unintelligible. For I shall not interrupt the discussion to explain the meaning of our technical terminology. It will be taken for granted that the reader has gained a clear conception of what is meant by de-automatizing an automatism, by the conditioning of a reflex, by the unwarranted mental supervision of a bodily mechanism, the threshold of body-consciousness and the primitive physiological reactions to fear. Moreover, it must be said that the only excuse for two chapters on sex, a subject about which a vast non-technical literature already exists, is the interpretation of abnormal sexual behaviour as arising out of just these general psychosomatic concepts.

Contrary to popular belief the female of our species is far less prone to psychosomatic disorders of sex than the male. She is far more liable to organic disorders in this sphere, she has to face far greater bodily hazards and though she is more exposed to emotional injury she seems to be psychosomatically more robust in her sexual adjustments, just as she is more enured to suffer real pain without protest.

Much if not most of what we men are all too apt to describe as hysteria and neurotic behaviour due to an unsatisfactory gratification of her sexual appetite does not arise out of her sex organs at all. It is a rather crude masculine approach to assume that with physical gratification all can be set right.

As already pointed out, in woman the dissociation of sex from its biological purpose has not gone as far as in the male. The act is not nearly as much an end in itself. It has more the nature of an incident in a highly complex emotional fabric reaching down into great depths of primitive biological instincts. It is the turbulence of these instincts, the biologically justified yearning for the security, protection, care and tenderness in which she can carry and bear her children which when thwarted gives rise to her psychosomatic symptoms. It does so to a far greater extent than her yearning for the pleasurable performance of the sexual act.

In women, therefore, it is these deep-seated, elemental instincts, rather than disturbances of the mechanism of orgasm, which throw up bodily reflections. That is why it is possible for a woman to make a good wife and a perfect mother, and why she seems able to lead a happy contented existence without major emotional conflicts even if she has never experienced an orgasm in her life—a thing unimaginable in the male and thus difficult for him to understand.

Similarly a woman yielding to a surfeit of sexual indulgence can never be satisfied unless she has a nest and a breadwinner on whom she can rely in case she should, in the performance of her duties to the species, become incapacitated.

Many women are loathe to admit the existence of these normal instincts. In a world of man-made values they seem to be ashamed of them and struggle to argue away or ignore the reality of their femininity, just as in a woman's world the male would be involved in a perpetual struggle with his lusts. We do indeed see that in civilizations which have only recently outgrown or are still in the process of outgrowing the matriarchial state the suppression of male concupiscence is very much in evidence. One need only compare the Hindu with the Muslim culture to see this clearly.

In man the post-adolescent period of his life is the one in which he is most liable to psychosomatic disorders related to the sexual sphere. In women this is not a very liable phase. Most of her troubles cluster round the menopause, but here again the strictly sexual sphere is only indirectly responsible. During the change of life—a very stupid man-made expression by the way—there is an unusually great strain on the autonomous nervous system which is called upon to make up for the bodily disharmony caused by the decreasing function of the ovaries.

During the course of 30 to 35 years it has adjusted itself to the presence of this important glandular activity. It takes some time before it learns to do without it. That, however, is a purely bodily matter. The psyche has nothing to do with it. The menopause is a normal period of readjustment which, left to itself is sooner or later satisfactorily accomplished after a series of such physical discomforts as result from temporary autonomous embarrassment. Sweating, hot flushes, emotionally unmotivated activity of the tear glands, palpitation

and a multitude of vague abdominal disturbances are such discomforts. A woman who accepts them for what they are and who is comparatively free of emotional conflicts finds that she can, if not cheerfully, at least bravely put up with them.

Not so the woman with overt or hitherto latent conflicts. She suffers actually. Her body, already running at a high autonomous pitch is particularly sensitive to emotional reactions.

To a much lesser degree she may have experienced something similar during the days of her menstrual period. Emotional things which formerly she could pass over lightly because her autonomous nervous system, settled in a steady routine, could comfortably make the necessary adjustments below the threshold of consciousness now assume gigantic and threatening proportions. They produce violent bodily reactions rising far above the threshold because all the latitudes of sub-threshold adjustment are already fully occupied, making up for the gland that has dropped out of the running. The result is as we have seen in Part I a further lowering of the threshold, an apprehensive mental occupation with the physical symptoms and the organs to which they are related, the heart, the intestines, the skin and the tear glands, but not, be it noted, the sex organs. Very soon the familiar vicious circle is established.

From the psychosomatic point of view, modern medical science has further complicated matters by furnishing us with the means of fully replacing a failing ovarian function with the isolated ovarian hormone or certain synthetic chemical substitutes which we possess and with which we can dramatic-

ally stop the bodily suffering of the menopause. By artificially replacing the ovarian function we can give the struggling autonomous system a rest and allow it to return to its former level of equilibrium. This, of course, at once eases the sensitivity to superimposed emotional strains. The patient feels remarkably relieved.

Now this would be very well if the mechanisms involved were always fully appreciated and if such drugs were used exclusively to ensure a brief period of rest from an ultimately inevitable struggle for readjustment. Unfortunately the prompt and impressive action of these preparations has led many to believe that severe menopausal suffering is purely physical and that extraneous emotional stress can be ignored.

The substitution of a failing ovarian activity by artificial means merely serves to camouflage emotional conflicts which remain ready to spring again into evidence as soon as the medication is stopped. Moreover, they prolong the process of menopausal readjustment. In many cases their temporary usefulness outweighs these disadvantages; but I have yet to see a case of severe menopausal distress without an extraneous emotional conflict. If it can be elucidated the patient is much more profoundly and lastingly benefitted than by temporarily blunting its acuity by artificially interfering with a normal bodily phase of development.

It is true that many of these conflicts yield only to a laborious psycho-analytical probing, but a woman who can be convinced that some such conflict is responsible for the intensity of her suffering and not a bodily disorder, has already advanced a

long way towards the recovery of sufficient strength to face squarely those physiological difficulties to which all womanhood is heir.

We now turn to a different female problem. A condition generally known as frigidity. This term is again a typical invention of the male mind and expressive of his own attitude to sex. He regards frigidity as a sort of female impotence which it is not. A woman can be sterile but she can never be impotent. Though a woman may be bitterly disappointed because she is missing a physical pleasure or be despondent that she cannot evoke the intensity of feeling which her male partner requires to achieve the fullest satisfaction of his desires, this hardly ever leads to a repressed feeling of inferiority—again a thing very difficult for a man to understand because with him a sexual failure is wrought with misery, self-reproach and often terror which he tries to repress.

In a woman orgiastic failure hardly ever produces such violent and elemental emotional reactions. By virtue of her securely passive role she is able to rationalize her shortcomings in this respect far more completely than can the male.

Her ability to do this saves her from insoluble emotional entanglements. If she loves her partner she feels sorry for *him* not for herself. Therein lies the fundamental difference.

Frigidity, unlike male impotence, is not a vicious circle. This is not so; each successive failure more securely blocks and impedes subsequent chances of success. It is usually something fixed not, as in so many of the psychosomatic disorders with which we have dealt in the preceding chapters, a case of the

complaint itself being the cause of its continuance. It is not even a case of an automatism having become de-automatized, which as we shall presently see is such an important factor in male impotence.

A woman utterly frigid with a partner she deeply and sincerely loves may be able to reel off an orgasm with a partner to whom she is physically attracted but whom she neither respects, admires nor would care to live with, much less choose to father her children.

Contrary to our custom we have spent some time saying what frigidity is not. That is because it can have roots going into many directions. It may be a relic from the virginal shock of defloration, it may be due to apprehension regarding yet another pregnancy, irritating or, to the female way of thinking, ridiculous mannerism of her partner, a preoccupation with other problems of her own, such as the nigger in the woodpile described in the last chapter of whom she cannot clear her mind sufficiently to produce that cheerful relaxation and abandon necessary for the successful accomplishment of the female orgasm. For some women the mere presence of an impatient partner in their bed is sufficient to start a train of realistic reasoning about how to be most accommodating to "the poor dear" and do all that is to be expected of the good and faithful wife that she is. They are so anxious to please their husbands that they forget to please themselves. These women are not *cold*; on the contrary they are warm, full blooded and emotional in the best sense. It is only the reasoning with which they approach the sex act that is cold and realistic. It prevents them from abandoning themselves to

their senses.

Some women appear to be frigid only because they have a powerful homosexual streak in their sexual pattern. Given the knowledge of its existence and an opportunity to follow this inclination they can become unbelievably passionate.

Many women, unable to achieve orgasm in sexual partnership, experience no such difficulty when growing sexual tension induces them to relieve it by solitary masturbation, a fact which has induced many male students to believe that the masturbation is responsible for the frigidity. This is certainly wrong, and leads to entirely wayward efforts at correction.

Though it is usually the male who complains of frigidity in his partner, many women seek relief from their difficulty, particularly those who in the past have experienced normal orgasms or who find that even now they very occasionally succeed, especially when under the influence of alcohol which dulls the sharp edge of their reasoning.

Unfortunately we cannot give them a hard and fast formula to help them over their trouble, at least not one which would be compatible with the ethics and conventions of our society. All we can do here is to assure them that in the vast majority of cases the condition is psychosomatic not somatic and that the proper authorities to turn to are the psychiatrist as well as the gynaecologist who can then most usefully collaborate.

Apart from these two conditions, severe menopausal distress and frigidity, there are a few other rare psychosomatic disturbances of the female sex mechanisms. Of these vaginism is a typical

example. It is an involuntary cramp of the vaginal ring-muscles which can either render the introduction of the male member exceedingly difficult and painful if it occurs at the beginning of attempted intercourse or which grips the member so tightly after introduction that withdrawal is impossible. In dogs, as we all know, vaginism is a normal feature of copulation. In humans it is an ancient survival of sex fear and may once in more savage days have been a useful safeguard against rape.

Even today one still encounters cases that have been treated rather crudely and naively with mechanical dilatation. The fact that any approach to the genitals with an examining finger or an instrument results in a reflectory cramp, misleads the unwary to assume that the vagina is anatomically narrow, where investigation under general anaesthesia proves it to be normal.

Vaginism is invariably an expression of fear and in such cases psychological harking back almost invariably casts up the clue which can then be rationalised and thereby dislodged from its troublesome, though secure, repressed position. Only *after* that has been successfully accomplished may a dilator be used once to demonstrate to the patient the normality of her organs.

In woman emotional conflicts related to her sex life usually express themselves through the medium of other organs. There again she differs fundamentally from the male whose emotional sex problems are particularly apt to express themselves in disturbed functioning of his sex organs.

A woman may suffer from psychosomatic menstrual trouble on account of an anxiety only remotely .

connected with her sex life, such as, for instance, worry about a sick child or parent, financial embarrassment or social ostracism. Yet on the other hand the unfaithfulness of her husband, divorce proceedings, unrequited love, usually produce non-sexual symptoms such as any or several of those dealt with in the preceding chapters. She is also particularly prone to respond to sexual conflicts with so-called allergic symptoms.

A woman has a marked ability to rationalize her sexual emotions to a considerable degree. This tends to divert physical manifestations of what remains unsolved away from the sex organs. It expresses itself elsewhere in the body. On the other hand she has no special capacity to rationalize non-sexual emotions. These are, therefore, particularly prone to upset the delicate nervous and glandular mechanisms which control her sexual cycle.

This explains what at first sight seems paradoxical, namely that in women sexual conflicts lead to extra-genital symptoms whereas conflicts not concerned with her sex life produce symptoms associated with the genital organs. A strange reversal of what one might anticipate and one to which there is no parallel in the male.

Recent work on the psychological conditioning of pregnant women towards the labour of childbirth clearly indicates that many difficulties of labour are of psychosomatic origin. Here a vicious circle is operating. Fear produces tension, tension produces cramps, cramps produce pain and delay the expulsion of the foetus which again increases the fear and so the trouble mounts up and up. Experience shows that if the initial fear can be eliminated from the

onset a surprisingly quick and easy confinement is the welcome result. That too is why a good old experienced midwife with limited real knowledge but an inexhaustible repertoire of superstitious patter can be much more psychologically helpful to the woman in labour than the expert obstetrician with his suggestive bag of terrifying instruments.

Even during pregnancy the anticipation of the dreaded event can lead to psychosomatic disturbances. They clear up remarkably once the fear is overcome, fear so often instilled by the hair raising experiences with which older women often regale their younger sisters preparing for their first confinement.

Finally a few words about such emotional conflicts as are peculiar to women; childlessness in a happy marriage, particularly when with the onset of the menopause the last hope begins to wane, is a well-known and common example.

Equally common but much less generally appreciated by the male is the agonizing awareness with which many women follow the fading of their youthful bloom and the inexorable accumulation of fat. Such women can go to pieces emotionally if they are restricted in the use of all the little subterfuges of dress and make-up which their sex has devised.

What we men are apt to regard indulgently as the foibles of a flippant weaker sex has for them a grim reality, quite beyond man's comprehension. It can have an emotional background, only comparable with that which he experiences in regard to his erection. A woman regards the deterioration of her figure with the same horror that man contemplates impotence. Her efforts to fight it with

medicines and diets are not any more ludicrous than the antics he performs with patent medicines. She certainly gets far less sympathy and understanding from her male medical adviser when she begs to be relieved of an insiduously accumulated inch.

Even though it has a glandular foundation—more frequently, pituitary than thyroid—there is a psychosomatic aspect to many cases of obesity. There are psychological mechanisms, deep-rooted in normal infancy, which permit the ingestion of food to replace to some extent an unsatisfied sexual longing. It is possible for a sexual appetite which is repressed to be transmuted into an oral appetite which is then given a free rein. Such a person, male as well as female, gets caught in yet another vicious circle. The fatter they get the more their sexual possibilities recede, and the more uncontrollable their appetite becomes.

For obvious reasons this vicious circle is much more dangerous to women, emotionally dependent on their appearance as they are. It very soon leads to other psychosomatic disorders. Thus improving a female psychosomatic patient's appearance, be it by reducing, plastic surgery, the beauty parlour or the dressmaker, can be a very important form of treatment, yielding results quite beyond the expectations of a man. It can be much more than a whim of fashion. In women cosmetics are not frivolous, they can play a major role in straightening out a jagged emotional personality.

I feel I owe my male readers no apology for this chapter. My lady readers I must however beg for indulgence. I am a mere man trying to expound their difficulties, a thing their scientifically trained

sisters so rarely attempt. I realise that in this enterprise I am severely handicapped. An honest effort at trying to see things from a point of view which is not naturally my own has produced a style possibly cumbersome and awkward. This may make a second reading of some paragraphs necessary in order to grasp what I am endeavouring to convey. For this I can do little else than apologise.

CHAPTER XVI

The Emotional Weakness of Manhood

THE male's emotional background to sex is far simpler and much more superficial than that of the female. He has a powerful urge with a single purpose. Its gratification is entirely pleasurable and as far as he is concerned unencumbered by major consequences of a bodily kind. All his sexual emotions cluster round the performance of the act itself to a much greater degree than is the case in the female. His psychosomatic sexual troubles are essentially disturbances in the mechanics of copulation, the erection and the seminal discharge. We shall deal with them under four headings: the involuntary nocturnal emission of semen; premature discharge or ejaculation; psychosomatic impotence; masturbation or self-abuse. In each case we shall find a misconception about the true extent of man's sexual capacity firmly entrenched at the root of the trouble. It will be our object to dispell this misconception and thereby clear the path along which normal reflexes can then again resume their course.

As far as his sex life is concerned man is a superstitious and easily beguiled creature. He is ever ready to jump to the most appalling conclusions and rarely takes the time to reason things out rationally. This is because he is perpetually haunted by the terror of loosing his manhood, as he calls it. He is always ready to lap up any scrap of nonsense artfully dangled in front of him and placing his sex in the same category as his drink and his tobacco.

Something in which indulgence is liable to have alarming repercussions.

Sex like hunger is a physiological urge as essential for the maintenance of the species as hunger is for the maintenance of the individual. It is, unlike hunger, hedged in with powerful taboos built up on account of the partial dissociation from its biological purpose. These taboos are the price man pays for using his sex with only a pleasure seeking motive, ignoring and actively circumventing the biological one.

Man's reasoning brain has opened to him the means and ways of obtaining many biologically unmotivated pleasures. Their abuse is held in check by a feeling of guilt. This is a most useful arrangement and it is only when the check becomes so insuperable that even minimal indulgence is blocked that trouble arises because an almost uncontrollable bodily urge categorically demands some form of satisfaction.

The Involuntary Nocturnal Emission: To men who have developed an abnormally powerful sexual check—usually a result of being misinformed about masturbation—a wet dream is a most unwelcome incident. They are apt to interpret it as evidence of sexual weakness. They feel annoyed that their efforts at continence should be thus surreptitiously sabotaged. They are often shocked at the bizarre contents of the erotic dream that accompanies the ejaculation of semen. They feel tired, listless and washed out the next morning. They resent the loss of “valuable body fluids” and conclude that a further abstinence from women is indisputably necessary. They act upon this resolve and get more wet

dreams. Their alarm grows and very soon they are spinning helplessly in their own pathetic little vicious circle.

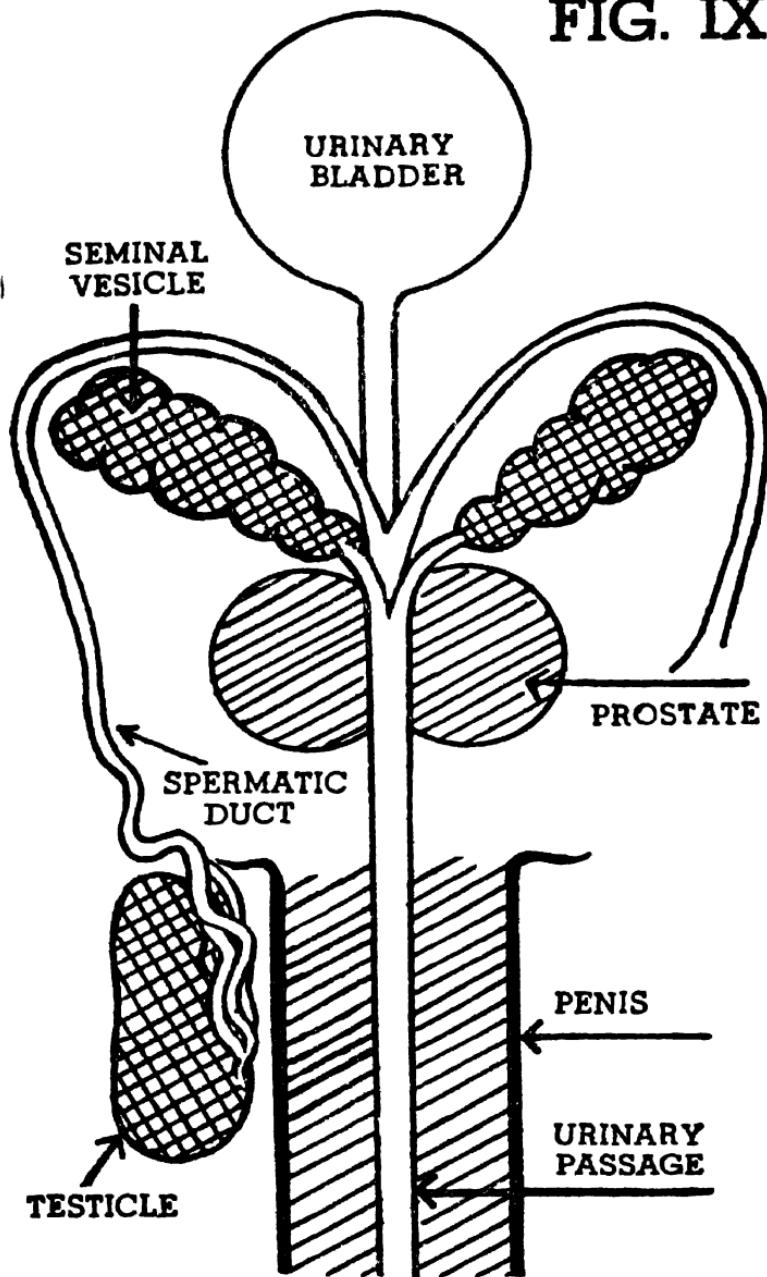
On the other hand the man who has no abnormal sexual inhibitions reacts to a wet dream quite differently. He says to himself, "Hallo! Looks as if I'm getting a bit overcharged. Funny dream I had. Rather nice now that I come to think of it. How good and fresh I feel this morning. Suppose it's high time I got married. Seems a bit of waste this way."

If you will please refer to Diagram IX, on the next page I will explain how the seminal discharge is performed. In the testicle the production of semen is a continuous process which goes on night and day. As the semen is produced it moves up the tube which we call the spermatic cord and is stored in the seminal vesicles in the groin. These little sacks have a powerful musculature in their walls. In the act of ejaculation they contract and expel part of their contents through the prostate where it is diluted with mucous, and then moves on into the urinary passage from where it is ejected in a rapid sequence of bursts at the height of the orgasm.

The contraction of the seminal vesicles is an autonomous reflex, over which we have only a limited control. The degree of conscious control depends on the filling. When the wall of the vesicle is fully distended with stored semen we have practically no control over its contraction which occurs at the slightest sexual stimulation, or, indeed, as in a wet dream, without any conscious stimulus. When the vesicle is not under tension its contraction is only elicited by strong stimulation.

A wet dream, therefore, is always an indication

FIG. IX.



of an overfilled vesicle. It is nothing other than an overflow which prevents a back pressure on the testicles.

A wet dream never empties the seminal vesicle, it merely relieves excess pressure which is again built up more or less rapidly by the testicle, resulting in another release through this safety valve, free to operate only when the conscious mind is eliminated in sleep.

Rather than being a sign of weakness a nocturnal emission is always a signal that the sexual outlet is inadequate. It indicates that the body demands more sexual gratification than it is receiving at the time.

Short of castration, there is only one way to stop wet dreams and that is to replace them by some other form of sexual outlet, such as coitus or masturbation; continence will only increase their frequency.

Of course, there is not the slightest reason why a man should get alarmed about his wet dreams which are convincing proof of a satisfactory potency. It is the misunderstanding of their true significance which prepares the ground for the purely psychosomatic aftermath of depression, exhaustion and fatigue so frequently experienced by those who are sexually inhibited.

Such patients have an idea that their body has been "drained" of some vitally precious fluid and that this is weakening in much the same way as a loss of two pints of blood would be. This is nonsense. Firstly, because semen is a fluid of no particular importance to the chemical turnover of the body that produces it. As soon as it has been

prepared by the testicles and stored in the seminal vesicles it can take no further part in the body's household. It has become an excretion like urine, sweat or mother's milk for which the body has no further use and which it tries to dispose of as quickly as possible.

It is therefore utterly impossible for an ejaculation of semen, prepared many days ago, to produce weakness or fatigue on account of the body having been deprived of it. A mother does not feel exhausted after her suckling infant has relieved the tension in her tumescent breast. On the contrary she feels relieved. In the same way it is normal for a man to feel relieved by sexual de-tumescence.

What then causes this feeling of depression, fatigue and exhaustion that the sexually inhibited so often feel after an ejaculation? It is nothing other than the apprehensive misinterpretation of the nervous relaxation which normally occurs after a sexual release.

The sexually inhibited always build up an enormous nervous tension without being aware that this tension is sexual. They repress its conscious acknowledgment and do not recognise its true nature. They prefer to call it irritability, nervous debility, and a failing power of concentration. When at last the sexual pressure bursts through their inhibitions, the result is a profound and sudden relaxation. But owing to their previous frame of mind it is not registered as such. Their reasoning mind plays a trick on them when, aided and abetted by notions about the physiological dignity of semen and a refusal to countenance sexual pressure, it translates nervous relaxation into exhaustion.

Mr. D. made precisely the same mistake in Chapter XIV when he thought he needed a tonic and did in fact need a sedative. Similarly our patient thinks he should practise continence when in fact his body is urging him to indulgence.

It is true that sex can be indulged in to the point of real exhaustion. This knowledge is particularly liable to make the inhibited think that their single sexual release has brought them dangerously near this point. The truth, if only they would realise it, is, of course, that they are actually right at the opposite extreme. Of this their wet dream is incontrovertible proof. They may be confidently assured that a long series of ejaculations at very short intervals—I mean several per day for a number of days—would be necessary to produce in them symptoms of real sexual exhaustion, a condition from which a young male recovers completely in less than a week of abstinence.

From this discussion of nocturnal emission several facts emerge. We shall meet them again in dealing with other psychosomatic disturbances of the male sex. Let us, therefore, once more briefly pass them in review.

Just as a man's appetite—a mental phenomenon—is no reliable indicator of his hunger—a bodily phenomenon—so a man's lust is no reliable indicator of his sexual power and reserves. The appetite may far outrun the hunger in which case the man overeats and gets fat or it may make demands less than the body's requirements, when the man becomes undernourished and loses weight. So it is with sex. If the lust—or libido as we call it—is repressed below the body's demand for outlet an abnormal

degree of tension results. Yet just as the person suffering from loss of appetite is not conscious of a feeling of hunger, so a suppressed libido renders the physical urge imperceptible as such.

The lean man can only gain weight by exceeding the dictates of his appetite. The inhibition of sex and its concomitant symptoms can only be overcome by exceeding the dictates of a thwarted libido. In both cases this calls first for a careful explanation of the true state of affairs and then a little courage on the part of the patient to overcome his dread of indigestion or impotence whichever the case may be. I hope we have now once and for all dispelled the myth of the existence of any mysterious vital functions of the semen in the body. It has none. The physiological value of an ejaculate, of the substance of which the body is deprived, is less than that contained in a tablespoonful of milk with which, as far as the body is concerned, it can comfortably be replaced.

We have further learned that the testicle produces sperm at a steady rate, quite independent of the frequency of the seminal discharge. The person who ejaculates daily produces no more sperm than the person who has a wet dream every three weeks. The difference in the quantity of fluid is made up by prostatic mucous secretion and has nothing whatsoever to do with testicular activity. The only difference is that the concentration of spermatozoa is greater after a period of continence. This is a matter of very small consequence because in any case the concentration of spermatozoa is so incredibly dense that such variations do not interfere with fertility to any great extent. Nor, does the content

of spermatozoa have any connection with potency or the intensity of the orgasm. Persons who for one reason or the other have no sperm in their ejaculate are entirely unaware of this. Except for the fact that they have no children, they lead a perfectly normal active and satisfactory sex life.

Finally we have learned that the speed of discharge in response to sexual stimulation and the possibility of its control depend mainly on the degree of tension in the seminal vesicles. Given an equal degree of stimulation, partially filled vesicles will take longer to spring into contraction than vesicles filled to capacity and being almost on the point of having to resort to a nocturnal emission to relieve the pressure on their distended walls.

Having thus dealt with a number of common misconceptions we can now turn to the discussion of another distressing complaint which in its mechanism is closely related to the wet dream.

Premature Ejaculation: The ability to maintain a prolonged erection without ejaculation is popularly and suggestively known as "Retention Power." It is taken as a sure sign of robust virility. Men pride themselves on this *power* because it enables them to give to their female partner all the time she may require for adjusting herself to the abandon which is an essential preliminary to reeling off her orgasm. Men graciously resort to all manner of queer subterfuges directed at lowering their own sexual stimulation to achieve this end. Though these may be commendable from their partner's point of view, such antics would be quite unnecessary if men knew a little more about the physiology of sex mechanisms.

Men who look upon prolonged erection as a *power*

will inevitably regard a rapid ejaculation as a weakness. The case of Mr. E. will show how this develops a psychosomatic vicious circle.

Mr. E. was a young school teacher who had married a most attractive and charming girl. For two years the couple had enjoyed to their heart's content an uninterrupted and particularly active sex life. This had consolidated their affection and given them a deep mutual satisfaction. Then the wife's mother fell dangerously ill. This kept her away from her husband for two months. Mr. E. missed her terribly and on a few occasions, he resorted to masturbation to relieve his tension. He felt that this was very wrong of him but decidedly preferable to the only other alternative in his distress, unfaithfulness.

When at last his wife announced her return his joyous anticipation of the resumption of a normal sex life knew no bounds. Her mother had recovered and when he met her at the station she looked lovelier than ever. Little did he realise the suffering that was in store for him.

The first attempt at intercourse was an utter failure such as he had never experienced before. He had a seminal discharge almost before he touched her. The shock which this produced was intensified by the fantastic notion that the disaster of his sudden "weakness" was in some mysterious way connected with his having yielded to the temptation to masturbate. In this state of abject horror a revival of his erection was out of the question.

His wife seeing his shame and perturbation became distressed and alarmed. With even less knowledge than her husband, she started to entertain the

almost unthinkable suspicion that he no longer loved her and that perhaps there was another woman. That night they both lay awake in the darkness, each grinding away at the mill of their own appalling thoughts.

For the next three days and nights they lived silently side by side under the dark cloud which had so suddenly and unexpectedly blotted the light out of their happiness. Neither of them dared to make the first move towards a resumption of sexual intimacies.

On the fourth night the husband had a wet dream. As usual he misinterpreted this as further evidence of fast waning virility, so he decided to keep away from his wife for a few more days, inspite of an increasing sexual desire.

After what he considered a reasonable period of hard fought abstinence he again approached her. As we who are in the know could have predicted, he had the same disastrous experience as on the first night.

This shattered them both completely. From then on with each successive failure and disappointment the intervening period of abstinence grew longer and longer, and as their tension, irritability, resentment and frustration mounted their libido receded more and more.

When I saw the couple about a year later Mrs. E. assured me that she had lost all interest in sex and had become frigid, while Mr. E. maintained emphatically that he was completely impotent and a nervous wreck. It took about six weeks to get Mr. and Mrs. E. back into their previous state of marital bliss. They now have three children and are none

the worse, though much the wiser, for their unhappy experience.

A man who has led an active regular sex life with other women before his marriage is liable to a premature ejaculation on his wedding night if he has previously observed a period of abstinence.

Yet the uninitiated bridegroom hardly ever gets into trouble of this sort. Either because he is masturbating in anticipation of the consummation and because he is stimulating himself with sexy literature from which he hopes to garner useful information for his impending entry into sex life or simply because he has never heard of premature ejaculation. In his healthy innocence he takes it for what it is, a particularly keen desire, a compliment to his young wife, a demonstration of his manly prowess, a sexual caper which in his mentally unapprehensive state passes smoothly and rapidly into the next more lasting and more substantial erection.

Thus then the treatment for this condition consists of firstly a careful explanation of its nature, followed by the direction to repeat intercourse as quickly as possible in the same night, making use of every device to achieve rapid re-stimulation.

It may be necessary to spend some time convincing the patient that in his condition a second coitus is always possible and that his apparent inability to produce another erection is caused by his unnecessary mental perturbation not by any sexual weakness. He should learn to transform his disappointment into pride. If then regular cohabitation is kept up the patient's 'retention power' will be fully restored.

Impotence: Gross under-development of the sex

organs, castration by the complete removal of the testicles, old age, that is, very old age, advanced diabetes and a few other rare degenerative diseases are the only known causes of real impotence. All other cases are psychosomatic.

In true organic impotence caused by the lack or absence of male sex hormone the artificial introduction of sex hormone produces immediate and often dramatic results. In psychosomatic cases their value is questionable because there the sex glands are working normally and require no further stimulation. The mechanism involved in psychosomatic impotence is entirely different. It is caused by fear and apprehensive preoccupation only.

Here is a simple example of psychosomatic impotence: all evening a man has been expecting an important trunk call which does not come through. He finally decides that it is now too late so he retires with his wife. She is in a playful mood to which he responds good-naturedly, but with less enthusiasm than usual because his mind is on the trunk call. In spite of this he gets a very satisfactory erection but just as he is about to begin coition he thinks he hears a faint ringing in the hall. He is not quite sure so he listens carefully and realises that it was the telephone in the next flat. However, it is too late. His erection has completely subsided. He has been "put off" so he gives up further attempts and tries to go to sleep. His wife correctly blames the next door telephone for her disappointment. She too is soon fast asleep.

Though this was a genuine case of psychosomatic impotence it has no further consequences because in the morning the husband gets his trunk call and

the whole incident is forgotten. Their next co-habitation is as satisfactory as ever. In this case the apprehension concerned the telephone message. It was legitimate and fully consciously realised.

Now let us see what would have happened if the anxiety had been less conventionally legitimate, something which had produced a feeling of guilt or moral inferiority and therefore had to be repressed. He would not then be consciously aware of it, yet it would produce exactly the same result if at the same moment when he thought he heard his phone some aspect of his preoccupation flashed across his mind only to be hurriedly ducked below the surface of his consciousness.

In this case the results are entirely different because he is unable to explain his sudden collapse. Both he and his wife become seriously alarmed. It starts him off on an endless and futile speculation about the cause of this unexpected catastrophe.

With a woman's more robust commonsense in matters pertaining to sex, his wife might try to reassure him.

"Never mind, darling, you're just tired and over-worked, forget all about it and go to sleep."

But he knows perfectly well that he is not that tired. To him the incident has a black and sinister significance.

He spends a restless night. Next morning he is tired and worn out and even during the day the horrid spectre of impotence looms before him, haunts him. He dreads the approaching hour of sexual intimacies. He is terrified of having to face a repetition of the previous night's disaster. A fate which inescapably is in store for him.

Soon we get the same psychosomatic mechanism we have met before coming into play. It is now no longer the little repressed incident responsible for his first failure which perpetuates his condition. It is the much more formidable fear of impotence which is at work.

He has lost every scrap of confidence in himself; he approaches intercourse with intense preoccupation and maintains a careful mental scrutiny over every phase of his performance. This, as we have seen in Part I, grossly interferes with the smooth induction of the complicated sequence of autonomous reflexes. Gradually he loses his libido and as the sex urge continues in full force he soon manifests the characteristic symptoms of insufficient outlet which he, of course, misinterprets. His wife too becomes exasperated and has but one wish: to be left alone and not be tormented by further demonstrations of her husband's shortcomings; utterly incomprehensible and faintly ridiculous as they appear to her.

Finally, a doctor is consulted. All too often this seals the patient's fate. A doctor who rashly accepts the patient's own diagnosis and glibly prescribes hormone injections can create havoc because not only do the injections fail to remove the psychosomatic block, they actually increase it by augmenting sex pressure without opening an outlet. Their failure to improve his condition clinches his conviction that he has passed beyond the limits of medical help. That he is on the verge of premature senility and might as well pronounce a final valediction to the pleasures of sex, youth and virility.

That is basically the process by which psychoso-

matic impotence becomes established. The example I have chosen is by way of illustration. There are endless variations of the theme.

Treatment begins with an emphatic denial that his is a case of true impotence. As proof one need but adduce the fact that these patients always have wet dreams and often a morning erection, neither of which exists in real impotence. This is followed by a careful explanation which may take as long as two hours. Then comes the harking back to the beginning of the trouble.

Once the emotional background has been cleaned up we begin with drastic sedation. Particularly the bromides induce a feeling of "To hell with it, who cares anyhow." This is exactly the frame of mind we require. Alcohol does the same thing and can usefully be employed in a moderate quantity as a preliminary conditioner for the first attempt at intercourse after the therapeutic session. In these cases which are invariably sexually overcharged there need be no concern about the adverse effects of an overdose of bromides or alcohol upon potency. The unexpectedly favourable effect they have in these cases can indeed be utilized as a further proof of the correctness of the psychosomatic interpretation of the disorder.

Psychosomatic impotence having much deeper emotional roots than premature ejaculation is rather more stubborn. It often calls for a full-dress display of all available psychosomatic weapons.

Just as in sleeplessness the normal conditioning, turning off the light, etc., can gradually be transformed into conditions inducing wakefulness, the same thing is a common occurrence in emotional

disturbances of potency. When this distressing complaint has existed for a longer period, that time, the room and an established routine of preliminary sex play gradually become transformed into conditions counteracting the erection owing to their long association with failure. It can thus be helpful to change as many of these conditions as possible.

To do this the couple should take a room in a hotel, surprise each other with new and different night clothes. The wife will need a new brand of perfume. They should have intercourse at unusual hours and in unusual places; all this helps to break down the old conditioning of failures.

Perhaps the most important direction is to ignore a failing erection should it occur and to continue sex play. If this is done cheerfully, for its own sake, as it were and not hurried over as a mere preliminary to an ulterior motive a powerful erection usually follows; sometimes just as the man thinks he is falling asleep or just after the female partner has actually fallen asleep. This erection must be taken advantage of at all costs. It will probably prove to be the forerunner of a complete restitution of normal sexual functioning.

Masturbation: Finally we have to deal with a form of sexual outlet which is now at last being generally accepted as legitimate and, when no partner is available, normal. So much has been written on the subject that most educated people know that it is completely harmless and has none of the baneful results our grandfathers ascribed to it.

In fact one can say that the young healthy adolescent, deprived of other forms of outlet, who does not occasionally masturbate is abnormal in the sense

that he has already taken the first step towards repression and inhibition of his libido, a step liable to lead to a long array of troubles in his later maturity.

Here we are not concerned with masturbation as such. What interests us are the false teachings of ignorant elders on the subject of masturbation because these harbour immense and dangerous propensities for creating psychosomatic mischief.

A youth having learned by himself or from others the possibilities of masturbation and having experienced the acute delight and the profound satisfaction he can derive therefrom, continues to masturbate innocently. He remains a lively, cheerful, contented lad, popular among his friends, eager to work and eager to play. Not only is he none the worse for his innocent indulgence, he is indeed all the better for it.

Then one day a terrible calamity befalls him in the shape of an ignorant old fool disguised as a fatherly and well-meaning friend who either has a "heart to heart" talk with him or ceremoniously presses in his hand one of those bloodcurdling tuppenny dreadfuls professing to deal expertly with difficulties of adolescence. This pernicious form of superstitious literature does not deal with the problems of adolescence at all—on the contrary it creates them. It wallows in a hair raising account of what happens to a boy who masturbates and never omits to furnish a long list of signs and symptoms by which its unfortunate victims are encouraged to assess the degree of harm already done and to follow with the necessary horror the progress of their physiological and mental disintegration.

All this utter rubbish the poor kid laps up believing it to be a most appalling revelation of the truth. He deeply regrets that no one had the sense to warn him before of the dangers of what to him was a pleasant little game. How could he know that he was well on the way to become a vice-ridden cripple.

As these books set out to scare the life out of their readers they are written with a satanic cunning that would be hard to beat intentionally.

By the time he has breathlessly reached the last page the boy has built up an inhibition which he will hardly ever be able to get rid of entirely.

What no amount of innocent masturbation could ever have achieved, has been accomplished in an hour. A horrid blight has been cast over the young and tender bloom of his emerging manhood.

From now on he tries to repress those memories of his stirring sex for they are loaded with guilt. He battles on bravely with fantasies, dreams and erections all of which have now become sinful and when sometimes they do get the better of him he suffers days and nights of agony and remorse.

His sex has become his biggest and most relentless enemy.

Exhausted in this continual struggle he becomes morose and loses the sharpness of youthful interest and zest. All this he attributes, not to his anxiety, but to his previous masturbation. It is just what it said in the book would happen. How true it all is, he thinks.

From years of this sort of conflict one can hardly expect a normal healthy attitude to sex to develop in later life. It rarely does. It is by far the most important reason for psychosomatic male sex trou-

bles in adult life. It is the one great cause of sexual inhibition beside which all others shrink into insignificance.

It often happens nowadays that in the consulting room an adult patient refutes the suggestion that his present difficulties are in any way connected with his youthful masturbation because he has long since learnt that masturbation is quite harmless and is convinced that all the dire after effects frequently attributed to it are just so much bosh and baloney.

This is sometimes apt to mislead the inexperienced. It is overlooked that at the time when he acquired this knowledge he was already leading a more or less normal sex life, and masturbation no longer presented an acute ever-present problem. He therefore skipped the emotional unravelling of his earlier sexual conflicts. His knowledge remained an intellectual reality and never became an emotional one.

Having found a reasonably satisfactory answer to his sex problems he blotted out the memory of his youth so ill-spent in fighting sexual bogeys. To him that is now a closed chapter which he would hate to have re-opened. Yet this is exactly what has got to be done. It has all got to be raked up again and disentangled in the light of his present knowledge for unless this is done, his theoretical information remains useless and only serves to disguise the truth, namely, that he is still struggling with the old blight on his sex, though he does not realise it.

We owe to the genius of Sigmund Freud a full appreciation of the extent to which sexual problems lead to psychosomatic disorders and though in the preceding chapters this has not been specifically repeated, in each instance, sex problems can and

usually do enter into the discussion of almost every disorder we have dealt with.

If the simple explanations I have given in these earlier chapters do not produce results we can be sure that there is a fat sexual grub gnawing at the patient's emotional roots. If we dig carefully from the periphery and sift the soil we will almost invariably find it. It is a delicate and sometimes tedious job for a clumsy emotional gardener injures the healthy roots and leaves the plant worse off than when it had only a maggot to cope with.

